IDAHO DEPARTMENT OF
HEALTH & WELFARE

Division of Medicaid

Provider Manual 2006

QUALIS HEALTH

July 2006

Idaho Medicaid Provider Manual:

Submitted by:
Qualis Health

July 2006

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List of Exhibits

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Section I: Purpose of the Qualis Health Care Management Program

The purpose of the Care Management program is to ensure that appropriate medical services are provided in accordance with state and federal regulations, statutes and policies to clients of Idaho Medicaid and the Division of Family and Community Services (FACS).

A. History of Peer Review

Quality Improvement Organizations (QIO) are organizations that review health care delivered in hospitals or other health care facilities. Reviews can be performed as a pre–service, concurrent or retrospective type of review.

The Federal government has expended significant dollars in developing and supporting review of care in facilities. In fact, this type of review was required by law in 1972 for Medicaid and Medicare programs. Qualis Health has been in existence since 1974, providing utilization and case management services, quality assurance services and special studies for Medicare, Medicaid and private sector entities.

Qualis Health changed its name from PRO–West in 2002 to recognize the expansion of the company's customers and services and better reflect its broad, multi–state involvement in health care utilization and case management and quality assurance services.

B. Corporate Background and Experience

Qualis Health is a private, non–profit organization with thirty–one years of experience in providing health care utilization and case management and quality assurance services across the Western Region of the country as well as nationally. We offer a range of programs, which are designed to control health care costs while improving the quality of health care delivered to consumers. These programs include traditional utilization management services such as pre–service, concurrent, retrospective chart and telephonic review, coding validation, and medical consultation. Qualis Health services designed for the managed care arena include the early identification of high–risk patients, specialty referral management services, consumer advocacy services and audits of access to care. In addition, Qualis Health's case management program is nationally recognized for excellence and superior results.

Qualis Health's quality improvement activities for the Center for Medicare and Medicaid Services (CMS) include the use of data and pattern analysis to identify opportunities to improve care. Qualis Health works in collaboration with facilities, providers, consumers and agencies to achieve a measurable impact on the quality of health care.

Qualis Health was awarded the utilization review contract with Alaska Medicaid in 1984 and the Idaho Medicaid contract in 1989. We also have provided medical peer review services and other related services to a number of other public sector clients as well as private sector clients.

For the three Medicare contracts we currently hold for Idaho, Washington and Alaska, the emphasis has evolved from traditional medical review to quality assessment and improvement services. For the Medicaid contracts held by Qualis Health for Idaho and Alaska, we have developed medical peer review for all levels and settings across the continuum of the health care delivery system. Qualis Health is a third party that is not controlled by organized medicine,

hospitals, or the insurance industry. As a result, we are able to objectively evaluate the medical necessity and quality of health care provided to the Idaho Medicaid clients.

In serving this diverse clientele, Qualis Health has assembled a team of professionals whose combined skills, experience and expertise are unsurpassed. More than 150 Board–Certified or Board–eligible physicians serve as consultants to the organization. They are trained in health care quality assurance and medical review. Health care reviewers are licensed nurses trained in medical review criteria. Qualis Health's case managers are licensed nurses who complete rigorous training in case management theory and practice; many have additional advanced health care degrees and extensive experience in specialty care. Qualis Health's data analysis staff include an epidemiologist and biostatisticians with graduate degrees.

Qualis Health's professional staff has well–established relationships with facilities and health plans, allowing for effective collaboration in health care evaluation and improvement. As part of this continuing effort to work in cooperation with the community, Qualis Health has also established a number of multidisciplinary councils as well as consumer, provider and physician outreach programs.

Qualis Health's Seattle, Washington office is accredited by the URAC/American Health Care Accreditation Commission, demonstrating compliance with the highest industry standards for pre–service, concurrent, retrospective reviews and case management services. Qualis Health is an active member of the American Health Quality Association and the Center for Clinical Quality Evaluation.

C. Mission and Vision

The mission of Qualis Health is to generate, apply and disseminate knowledge to improve the quality of healthcare delivery and health outcomes. Qualis Health's vision is to be recognized for leadership, innovation and excellence in improving the health of individuals and populations.

D. Definitions of Utilization Management and Case Management

Utilization Management (UM)

The evaluation of medical necessity, appropriateness, and efficiency of the use of health care procedures and facilities under the auspices of the applicable health benefit plan. Sometimes called utilization review or UR.

Case Management (CM)

A collaborative process that assesses, plans, implements, coordinates, monitors, and evaluates options and services intended to meet an individual's health needs through communication and available resources. The goal is to promote quality, cost–effective outcomes and coordinate care across the continuum of services.

Both UM and CM address:

- appropriate use of health care services
- efficiency or cost–effectiveness
- quality of care

E. Comparison of Utilization Management and Case Management

UM

- Reactive (responding to requests for service)
- Focused on specific treatment / units of service
- Limited interaction with providers and clients
- Goal is to address medical necessity of requested services

CM

- Proactive (identifying optional resources)
- Broader, more holistic approach
- Communication with clients and providers is key
- Goal is to coordinate care across the continuum of services

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Section II: Communicating with Qualis Health

A. Telephone System

The Pre–service and Concurrent Review program is entirely telephonic; therefore, Qualis Health depends upon the telecommunications system to make the program work effectively.

In light of the importance of the telecommunications system, Qualis Health has installed an advanced, state–of–the–art telecommunications system that includes a confidential voice mail system and an Automatic Call Distribution (ACD) group in the telephonic review area. This ACD group routes incoming calls to the intake representatives and nurse reviewers. In addition, a telephone monitoring system has been installed to allow directors/managers to supervise the responsiveness and performance of the intake representatives and nurse reviewers.

To reach Telephonic Review Services in the Seattle office of Qualis Health, call (800) 783-9207, and press 2. A caller may reach the voice mail system if an intake representative or nurse reviewer is not available immediately; however, the amount of time that the caller waits for the voice mail system does not exceed 35 seconds due to a programmed element in the system. If a caller does not access an intake representative or nurse reviewer directly, leave a detailed message. The voice mail system is monitored at least hourly to triage messages and to direct nurse reviewers so that callbacks are handled appropriately and efficiently.

B. Leaving an Effective Message

When accessing the voice mail system to leave a message, please follow the directions given. An example of necessary information is listed below.

1. Your name
2. Your telephone number, including area code, beeper number or extension
3. Physician full name
4. Client name (with the correct spelling)
5. Client I.D. number (Medicaid or FACS)
6. Client date of birth
7. Facility name
8. Date and time of admission or surgery
9. Diagnosis or surgical procedure
10. ICD–9 diagnosis codes and ICD–9 or CPT procedure codes
11. Case ID number for continued stay review

C. Facsimile (FAX) Submission of Review

Reviews may be submitted to Qualis Health via FAX machine at (800) 826-3836. Refer to Section VII, Exhibit 3 for a sample FAX review form.

The FAX must be legible and include all the necessary demographic and clinical information that is required to complete the review. Sample forms for submitting reviews via FAX are included in this provider manual (Exhibits 3 and 7). Providers may use their own FAX form as long as the information is complete. A FAX cover sheet with a confidentiality disclaimer is highly recommended.

If a provider does not submit all the necessary information or the required timelines are not met, Qualis Health reserves the right to request that the provider discontinue FAX reviews and resume telephonic reviews.

D. Provider Notification

Qualis Health **will not** send letter notifications on certified reviews.

Qualis Health **will** send letter notifications for all non–certified reviews and appeal reviews. These notifications will be sent to the Department, client, attending physician and facility.

Exhibit 1

Location of Review Functions for Qualis Health

The following review functions will be performed in the Seattle Office:

- Pre–service and Concurrent Reviews
- Retrospective Reviews less than 15 days
- Retrospective Reviews 15 days and greater
- All Retrospective IMD reviews
- Focused Case Reviews
- Expedited Appeals
- Standard Appeals
- Case Management

Qualis Health
Attn.: Care Management Department
10700 Meridian Avenue North, Suite 100
P.O. Box 33400
Seattle, WA 98133
Telephone: (800) 783-9207
FAX: (800) 826-3836
***Physician "Hotline": (877) 292-2615**

*A Care Management Department intake representative will answer and coordinate servicing this line with the Care Management nurse reviewer on the case.

Section III: URAC Time Frames

Utilization Review Decision–Making and Time Constraints

Who makes the utilization review decision?

Qualis Health is accredited by URAC for Health Utilization Management. This means that Qualis Health adheres to nationally recognized standards for performing utilization management. Licensed nurses perform initial clinical review and may certify care that meets InterQual® Criteria. If the clinical information provided does not meet InterQual® Criteria, or if, in the nurse's judgment, a physician should review the case, it is referred for clinical peer review.

With clinical peer review, a licensed physician reviews all available information and makes a decision on whether care should be certified or not. When a decision is made to not certify care, the attending physician has the opportunity to discuss the review and proposed care with a Qualis Health physician, prior to final determination. If the result of that conversation is not satisfactory for the attending physician, an appeal process is available.

What are the time frames for peer–to–peer conversation?

There are time constraints involved for potential non–certifications. The Qualis Health nurse reviewer will notify the facility utilization review coordinator of the potential non–certification and request that the utilization review coordinator contact the attending physician to offer the option of a peer–to–peer discussion. At the same time, Qualis Health's physician reviewer will, in most cases, independently attempt to contact the attending physician.

If a peer–to–peer conversation is desired by the attending physician, it is necessary to call Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time the day following notification of the potential non–certification. If the attending physician is not able to call within the stated time frame and an extension is desired, please notify Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time of the next business day.

If the case is non–certified after the peer–to–peer conversation, the stay will be non–certified retroactively to the day medical necessity was not met. If the **attending physician** does not call by 6:00 PM Mountain Time / 5:00 PM Pacific Time the following day, the case will be non–certified. The attending physician may use the physician "hotline," 1-877-292-2615, to discuss the client's case.

What are Qualis Health's review timelines?

The number of days allotted for each type of review is based on the URAC Health Utilization Management Standards. It is different for urgent review than it is for non–urgent review. If the review requires that additional information be gathered, clinical peer review to take place, or a peer–to–peer conversation occur, additional time is allotted.

What is considered an urgent review?

Case involving Urgent Care: Any request for a utilization management determination with respect to which the application of the time periods for making non–urgent care determinations a) could seriously jeopardize the life or health of the client or the ability of the client to regain maximum function, or b) in the opinion of a physician with knowledge of the client's medical condition, would subject the client to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

What is your recourse when you disagree with a Qualis Health review determination?

Please see Section XX of this manual regarding the appeal process. If, after an appeal, you still disagree with the Qualis Health determination, your appeal letter will outline the steps, which must be taken to request a hearing with the Idaho Division of Medicaid. See Section XX, Part C.

Qualis Health Medicaid UM Review Timeframes

Timeframes for UM Review Decisions

With all necessary clinical information received and no referral for clinical peer review, the timeframes are:

Review Type	Timeframes for Completion from Date of Notification to Qualis Health
Pre–service Review – Urgent	Three calendar days
Pre–service Review – Non–Urgent	Fifteen calendar days
Concurrent Review – Urgent	Three calendar days
Concurrent Review – Non–Urgent	Three calendar days
Retrospective Review	Thirty calendar days

When additional information is required to complete the review, the timeline is adjusted accordingly.

Qualis Health may choose to exercise a single extension of up to 15 calendar days on non–urgent reviews when there are reasons beyond the control of the organization that requires an extension. When this occurs, Qualis Health must inform the provider (by the date on which notice of the initial decision would normally be due) of the circumstances that require the extension and the date by which it expects to reach a decision. This single extension is not allowed for urgent care reviews.

Section IV: Health Insurance Portability and Accountability Act (HIPAA)

IDAHO DEPARTMENT OF HEALTH & WELFARE

DIRK KEMPTHORNE–Governor

KARL B. KURTZ–Director

JOSEPH R. BRUNSON, Administrator
DIVISION OF MEDICAID
BUREAU OF BENEFITS AND REIMBURSEMENT POLICY
CUSTOMER SERVICES UNIT
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 364-1818
FAX: (208) 364-1864

April 14, 2003

Medicaid Information Release 2003–31

TO: IDAHO MEDICAID PROVIDERS

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: HIPAA PRIVACY – COVERED ENTITIES

The new Federal Regulations called HIPAA (Health Insurance Portability and Accountability Act) allow the use and disclosure of identifying or protected health information between "covered entities" to provide treatment, payment or health care operations (45 CFR Part 164.506).

According to Idaho rule, Department employees and contractors may use and disclose records as necessary to perform normal business functions, including health treatment, audit and quality improvement, investigation of fraud and abuse, establishment of overpayments and recoupment, public health, or other functions authorized by law. Information will be made available to state and federal auditors and compliance monitors (IDAPA 16.05.01.100.05).

By way of clarification, written authorization from the patient is not required for covered entities to disclose identifying or protected health information to Department staff and Medicaid's Business Associate Contractors when there is a need–to–know for them to do their jobs.

Department Staff

Department staff performs a number of services necessary to provide clients with treatment, payment and normal health care operations including:

- Prior authorizations for services such as transportation (non–emergency medical), medical equipment, certain medicines and most brand name drugs when generics are available, physical therapy, certain vision services, and other services.
- Audits, investigations, and inspections in compliance with state and federal regulations.

- Health oversight activities such as monitoring the Medicaid program for fraud and abuse of services.

Medicaid's Business Associate Contractors

The Department has contracted with several organizations to conduct some of our health care operations. Agreements with the following business associate contractors authorize them to conduct Medicaid's health care operations on our behalf:

- EDS – claims payments
- Qualis Health – utilization and case management
- Thomas Young, MD – case management
- Myers & Stauffer – auditing services
- SWEEP – Medicaid's supplier for glasses (frames and lenses)
- Thomas Bruck, DDS – prior authorization of dental services
- ISU–DUR – drug utilization review
- Public Consulting Group – third party recovery

Your cooperation and assistance in sharing appropriate protected health information with Department staff and their business associate contractors will enable us to continue the administrative and operational procedures necessary to provide services and benefits to our clients while complying with applicable HIPAA regulations.

If you have questions, please contact Arlee Coppinger at 208-287-1177.

KA/dy

Section V: Provider Billing Concerns

Providers may call Qualis Health to investigate a discrepancy that has caused or has the potential to cause a claim to fail. Some examples of discrepancies that require investigation are as follows:

1. The date(s) on the Qualis Health review does not match the certified admission or discharge date on the claim.
2. Admitting or principal diagnosis and/or all procedure code(s) on the Qualis Health review do not match the code(s) on the claim.
3. Incorrect client Medicaid Identification number indicated on the Qualis Health review.
4. Case ID number (prior authorization or Case ID number) used for billing does not match the case ID number on the Qualis Health review. **Note:** the prior authorization or Case ID number must be noted on the claim.

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Section VI: Categories of Eligibility

There are times when Idaho Medicaid clients could be covered under another insurance or program, and the requirements for review may vary. The following examples will assist you in determining which review requirements will apply.

A. Dual Eligibility

Example 1

"Primary:" Medicare (Part A)
""Secondary:" Medicaid

→ **No Medicaid Review Required**

(If Inpatient Medicare Benefits have been exhausted, Qualis Health should proceed with a review for Medicaid.)

Example 2

"Primary:" Medicare (Part B)

"Secondary:" Medicaid

→ **MEDICAID Review Required**

Example 3

"Primary:" Other Insurance
(e.g., Blue Cross)

"Secondary:" Medicaid

→ **MEDICAID Review Required**

Example 4

"Primary:" Medicaid
or
"Secondary:" FACS

→ **MEDICAID Review Required**

Example 5

"Primary:" FACS

"Secondary:" None

→ **MEDICAID Review Required**

B. Ineligible Non–Citizen Emergency Medical Services

An ineligible non–citizen is a legal or illegal non–citizen who is eligible only for medical services necessary to treat an emergency medical condition, which can reasonably be expected to seriously harm the patient's health, cause serious impairment to bodily functions or cause serious dysfunction of any bodily organ part without immediate medical attention.

The Division of Medicaid will determine if the condition is an emergency and if the services to treat it will be covered by Idaho Medicaid. If the services are approved, Medicaid eligibility will begin no earlier than the date the client experienced the medical emergency and ends the date the emergency condition stops.

Submit requests for consideration to the local Self–Reliance Services (SRS) office in the county where the client lives. A list of the local offices with phone numbers is available at:

http://healthandwelfare.idaho.gov/

The local SRS office will notify each non–citizen applicant, and the provider who initiated the request of the determination for covered services. A prior authorization (PA) or Case ID number will also be sent to the provider for inpatient admissions over three days, which must be entered on the claim when submitting to Idaho Medicaid. For more information regarding required documentation, see Information Release 2003–29 in the Bulletins Section, Appendix D.

C. Pregnant Women and Children

Idaho Medicaid developed the Pregnant Women and Children's (PWC) program to help ensure that all women have access to prenatal and postpartum care. The ultimate goal is to ensure the health of mothers and infants. According to Medicaid policy, covered services for a female client with PWC coverage are limited to those that are clearly documented as meeting one of two criteria:

- Is the condition being treated a direct result of the current (or recently completed) pregnancy?
- If the condition is not treated, will it endanger the mother and/or fetus?

D. CHIP–B

The Children's Health Insurance Program (CHIP–B) was implemented July 1, 2004 to provide a limited benefit package to qualified children. Inpatient mental health services are limited to thirty (30) days per calendar year and transplants are not a covered benefit. For a complete list of service limitations, refer to Appendix D, Information Release 2004–27 and 2004–61.

Section VII: Pre–service Review

A. Purpose

Utilization review organizations have found that the most effective form of review takes place *before* the client enters the facility. The chief advantage is that inappropriate admissions can be avoided rather than contested after an expense is incurred.

The Idaho Department of Health and Welfare (the "Department") has determined that certain select diagnoses and frequently performed procedures will require pre–service review. This list of medical conditions and procedures is contained in Appendix A.

The Pre–service Review Program has six components:

1. Eligibility Verification: The Qualis Health intake representative will verify the client's Medicaid eligibility prior to the nurse reviewer performing a pre–service review. Qualis Health has computer access to Idaho Medicaid's AIM/MMIS system and is able to verify eligibility at each workstation. If eligibility is not current for the period of time in which the admission occurs or is scheduled, the review process will not proceed.
2. Healthy Connections Notification: Upon verifying current Medicaid eligibility, the intake representative will confirm whether or not the client is a participant in the Healthy Connections Program. If so, it is the responsibility of the intake representative to inform the primary care provider of the request for pre–service review (if the attending/requesting physician is not the client's primary care provider).
3. Surgical necessity review for select inpatient or outpatient non–urgent surgical procedures to validate medical justification for surgery.
4. Inpatient necessity/level of care review for select procedures to assure that certain procedures ordinarily performed on an outpatient basis require inpatient hospitalization due to other existing medical conditions.
5. Medical necessity review for select medical conditions to assure that inpatient hospitalization is warranted.
6. Review of admissions to Hospital Physical Rehabilitation, Chemical Dependency, and Psychiatric Units to determine the medical necessity of the admission.

B. Responsibility

Pre–service review is required for all inpatient admissions and outpatient procedures included on the select diagnoses and procedures list in Appendix A.

The client's attending physician is ultimately responsible for obtaining the pre–service review. The attending physician is most knowledgeable about the client's medical history and condition, however, Qualis Health will accept calls for pre–service review from the surgeon when applicable, physician office personnel, or facility personnel (i.e., utilization review coordinator, admitting office, patient accounts office). The nurse reviewer is to receive all of the appropriate clinical information to satisfy InterQual® Criteria before the pre–service review will be certified. A Case ID number and length of stay will be assigned at the time of the call if the review is certified.

Note: The Department also requires pre–authorization for a separate list of services and procedures not included on the Qualis Health list. The list is accessible at:

http://www.healthandwelfare.idaho.gov/

Click on: Medicaid Provider Information
Select: Handbooks for Providers
Select: Physicians/Osteopath Guidelines (Section 3)
Select: Medical/Surgical Review (Section 3.3)
Select: Prior Authorization (Section 3.3.3)
Or Select: Hospital (Section 3)
Select: Prior Authorization (Section 3.4)
Select: Medical Surgical (Section 3.4.16)

Contact information:

Idaho Medicaid
Attention: Medical/Surgical Review
Phone: 208-364-1839
FAX: 208-332-7280

C. Requirements

1. Pre–service review is required for all inpatient admissions and outpatient procedures included on the Select Diagnoses and Procedures List (Appendix A). However, a review is required only if the admitting/principal diagnosis or procedure (inpatient and outpatient) is on the select list and the facility is approved for Medicaid coverage by the Department.

2. **Important: The requirement for pre–service review for inpatient or outpatient procedures (non–urgent or urgent) pertain to Medicaid and FACS clients. Qualis Health will require a minimum notice of one week prior to all non–urgent inpatient hospitalizations or outpatient appointments for those diagnoses or procedures included on the select pre–authorization list. (Refer to Appendix A.) Requests for pre–service review may be made up to four weeks prior to the scheduled admission or procedure.**

   Non–urgent pre–service review approvals are valid for four (4) months, with the exception of all transplant approvals, which are valid for six (6) months, from the date of initial authorization.

   Qualis Health may request updated clinical information from providers prior to performing the procedure. If an admission or procedure date changes, the provider must notify Qualis Health prior to the scheduled admission.

D. Time Frames for UM Review Decisions

With all necessary clinical information received and no referral for clinical peer review, the timeframes are:

Review Type	Timeframes for Completion from Date of Notification to Qualis Health
Pre–service Review – Urgent*	Three calendar days
Pre–service Review – Non–Urgent	Fifteen calendar days

When additional information is required to complete the review, the timeline is adjusted accordingly.

Qualis Health may choose to exercise a single extension of up to 15 calendar days on non–urgent reviews when there are reasons beyond the control of the organization that requires an extension. When this occurs, Qualis Health must inform the provider (by the date on which notice of the initial decision would normally be due) of the circumstances that require the extension and the date by which it expects to reach a decision. This single extension is only allowed on non–urgent reviews; it is not allowed for urgent care reviews.

***Definition of Case involving Urgent Care:** Any request for a utilization management determination with respect to which the application of the time periods for making non–urgent care determinations a) could seriously jeopardize the life or health of the client or the ability of the client to regain maximum function, or b) in the opinion of a physician with knowledge of the client's medical condition, would subject the client to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

E. Procedure

Operational hours for Idaho Medicaid and FACS review are as follows:

6:30 AM to 5:45 PM Pacific Time
7:30 AM to 6:45 PM Mountain Time
Monday through Friday

The physician or designated personnel may call Qualis Health at:

PHONE: 1-800-783-9207
FAX: 1-800-826-3836

This number will directly access Qualis Health Medicaid intake representatives or nurse reviewers. In the event that no one is immediately available, callers have the option of waiting on the line for the next available person or leaving a message in the voice mail system. Instructions are clearly stated for accessing the electronic voice mailboxes which are monitored at least hourly so that nurse reviewers can prioritize those messages and return calls in a timely and efficient manner. Refer to Exhibit 3 for the *Pre–service Review Request FAX Form*.

Qualis Health intake representatives will collect the following basic information and verify Medicaid eligibility for those reviews requiring pre–service review:

1. Client name

2. Client birth date
3. Complete client address
4. Sex of Client
5. Client I.D. number (Medicaid or FACS)
6. Admitting diagnosis and ICD–9–CM code
7. Physician name
8. Physician address
9. Physician phone number
10. Physician Medicaid provider number
11. Facility name
12. Facility address
13. Facility phone number
14. Facility Medicaid provider number
15. Current principal diagnosis and ICD–9–CM code
16. Procedure to be performed, including the ICD–9–CM code and/or CPT code
17. Justification for the hospitalization and/or client symptoms
18. Treatment proposed/provided
19. Admit date and/or surgery date

The Qualis Health nurse reviewer will review the clinical information, applying *InterQual® Criteria for Non–physician Review*, assign the length of stay and will establish the date when a recertification/continued stay review will be conducted if the client has not been discharged. Refer to Exhibit 2, *Pre–service Review Flow Chart.*

If the Severity of Illness (SI) and Intensity of Service (IS) screening criteria are met, the Qualis Health nurse reviewer will issue a Case ID number and the review will be certified at the time of the initial telephonic review. Qualis Health nurse reviewers will follow the Qualis Health policy regarding referral to physician review. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer within one (1) working day of decision.**

Qualis Health certification indicates only that the admission or procedure is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Idaho.

If the SI/IS screening criteria are **not** met, the Qualis Health nurse reviewer will refer the review to a Qualis Health physician/practitioner consultant who has a current, unrestricted license in the same licensure as the ordering physician and is qualified to render a clinical opinion about the medical condition, treatment, or procedure. The physician/practitioner consultant will review the clinical information and either certify the admission or issue a potential non–certification. In the event of a potential non–certification, the attending physician will be given an opportunity to discuss the review with the Qualis Health physician/practitioner consultant. If a conference call is requested, the Qualis Health physician/practitioner consultant and the client's attending physician will discuss the treatment plan as well as appropriate

alternatives. Following the discussion, the Qualis Health physician/practitioner consultant will either certify or non–certify the admission.

F. Non–Certifications

If the Qualis Health physician/practitioner consultant non–certifies the admission, the Qualis Health intake representative will notify the appropriate provider (e.g., attending physician, facility) by telephone. Qualis Health will send non–certification letters within one working day to the following parties: the client, attending physician, facility QIO contact person, and the Department.

The non–certification letters will contain justification for the non–certification and an explanation of the right to request an appeal of Qualis Health's initial non–certification determination. Refer to Section XX of this manual for a detailed description of the appeal procedure.

The Department will not reimburse providers for services that have been non–certified by Qualis Health, with the exception of non–certifications that are reversed as a consequence of an appeal review by Qualis Health or an appeal hearing by the Department.

NOTE: There are time constraints involved for potential non–certifications. The Qualis Health intake representative or nurse reviewer will notify the facility utilization review coordinator of the potential non–certification and request that the utilization review coordinator contact the attending physician to offer the option of a peer–to–peer discussion. At the same time, the Qualis Health physician/practitioner consultant will attempt to contact the attending physician to discuss the case further.

If a peer–to–peer conversation is desired by the attending physician, it is necessary to call Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time the day following notification of the potential non–certification. If the attending physician is not able to call within the stated time frame and an extension is desired, please notify Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time of the next business day.

If the case is non–certified after the peer–to–peer conversation, the stay will be non–certified retroactively to the day medical necessity was not met. If the **attending physician** does not call by 6:00 PM Mountain Time / 5:00 PM Pacific Time the following day, the case will be non–certified. The attending physician may use the physician "hotline," 1-877-292-2615, to discuss the client's case.

G. Procedure for Urgent Inpatient Admissions and Outpatient Procedures

This provision of calling Qualis Health on an urgent inpatient admission or procedure or outpatient procedure only applies to those select diagnoses and procedures that require pre–service review, as listed in Appendix A. For those diagnoses and procedures not included on the select preauthorization list, review back to the day of admission will be required after three (3) days of facility confinement (at **day four**). Refer to Exhibit 6. The care and treatment of the client never should be delayed, particularly in urgent situations, in order to obtain Qualis Health certification. The same review guidelines apply when obtaining certification for post–procedure/post–admission as apply during the non–urgent pre–service review process.

When an urgent admission or procedure which is on the pre–authorization list (Appendix A) occurs either during normal business hours (7:30 AM – 6:45 P.M. Mountain Time / 6:30 AM – 5:45 P.M. Pacific Time) or on a weekend or legal holiday, providers or designated facility personnel are required to notify Qualis Health within one working day. This can be accomplished by calling the toll–free number during normal business hours. An intake representative or a nurse reviewer who will conduct the review will answer the call, or a detailed message can be left on the electronic voice mail system. A recorded message instructs the caller on how to access the voice mail system. In order for Qualis Health to prioritize call–backs appropriately, the pertinent information must be given when leaving a message (refer to Section II, Part B, *Leaving an Effective Message).*

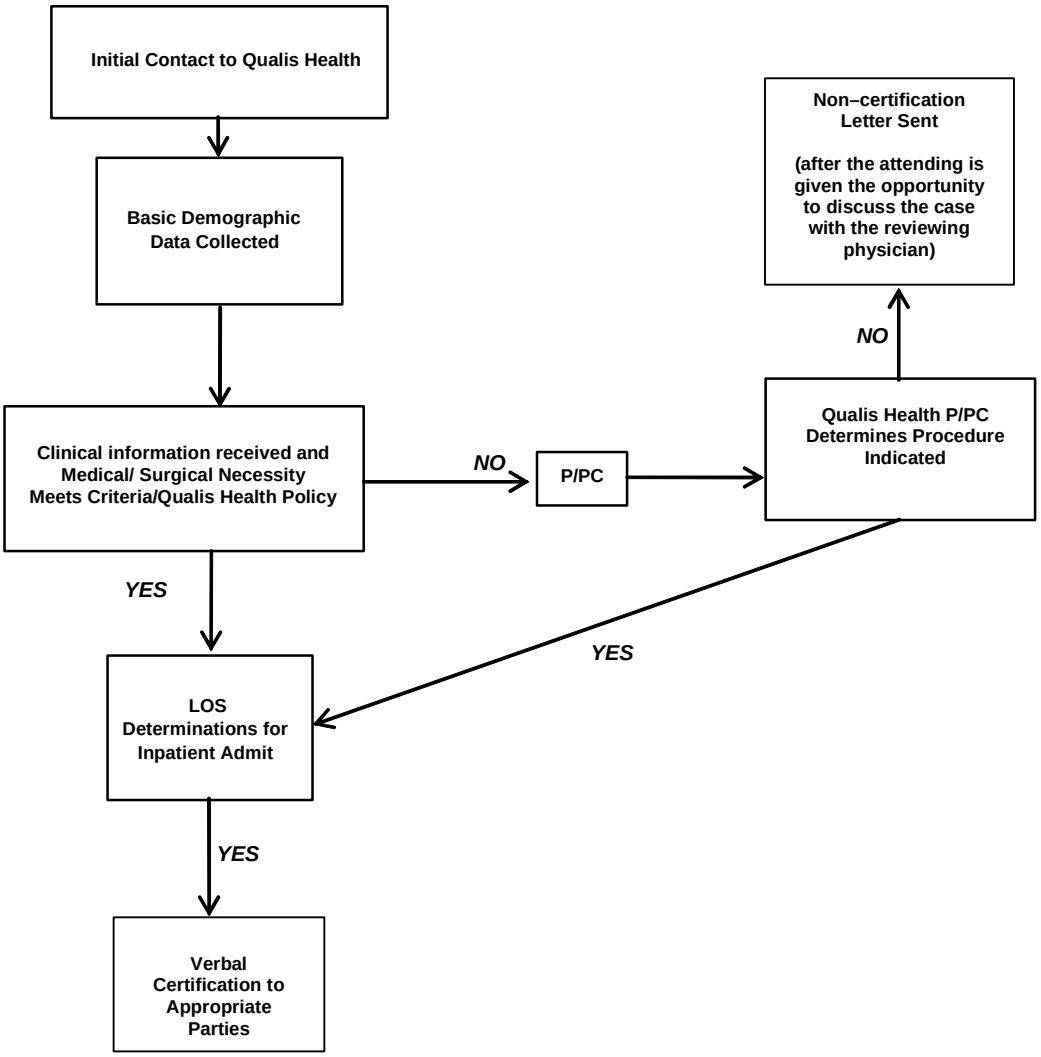
Leaving the aforementioned information in the electronic voice mail system does not complete the review process. It will be Qualis Health's responsibility to return the provider's call and initiate the review process. This does not mean the admission or procedure automatically is certified. The same review criteria will be used in determining a certification or non–certification. The same notification process for certifications and non–certifications will be followed, as previously stated in Parts E and F of this section.

H. Appeals

Refer to Section XX—Appeals

Exhibit 2

Pre–service Review Flow Chart



P/PC = Physician/Practitioner Consultant
LOS = Length of Stay

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Exhibit 3

Pre–service Review Request FAX Form

DATE: _____

ATTN.: _____

FAX #: _____ **PHONE #:** _____

FROM: _____

FAX #: _____

NUMBER OF PAGES (INCLUDING COVER SHEET): _____
If there is problem with the receipt of this facsimile, please call. _____ Thank you.

CLIENT/PATIENT NAME: _____

CLIENT/PATIENT DATE OF BIRTH: _____

COMPLETE CLIENT ADDRESS: _____

MEDICAID NUMBER: _____

REQUESTED ADMIT DATE: _____ **DIAGNOSIS CODE(S)** _____

PROCEDURE DATE(S): _____

DAYS REQUESTED: _____ **PROCEDURE CODE(S)** _____

CONTINUED STAY REVIEW? Y( ) IF SO, REFERENCE # _____

NEW ADMIT? ( ) TRANSFER ( )

SETTING: ☐ **INPATIENT** ☐ **OUTPATIENT** ☐ **PHYSICIAN OFFICE** ☐ **OUT OF STATE**
☐ **NON–URGENT** ☐ **URGENT**

PHYSICIAN NAME: _____ **PHONE #** _____
FAX # _____

FACILITY: _____ **PHONE #** _____
FAX # _____

CLINICAL INFORMATION: _____

_____

_____

_____

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Exhibit 4

Qualis Health
Inpatient Review Concept Template:

This is provided as a tool to help organize information that will help patients get medically necessary services at the right level of care and at the right time while meeting Qualis Health's need for appropriate InterQual® documentation. Please consider the following as a 'guide', not a requirement or guarantee of payment for admission or for continued stay review.

Demographics:

- Patient name, ID number
- Attending name, pager number and best time for a Qualis Health Medical Director to call if needed
- The day or dates under review

SI [Symptom Intensity]– How sick is the patient? This places the patient's services in context with their clinical condition and is needed both for initial review and for concurrent review

- What is the main clinical issue?
- Abnormal vital signs?
- Pain present– where, what is cause?
- Neurological Status: alert to obtunded
- Brief description of diagnostic tests [especially if lab or x–rays are abnormal]
- Any consultations and evaluations or procedures?

IS [Intensity of Services]– What care is the patient receiving?

- IV medications and frequency
- Any IV PRN meds given for nausea, pain? How often each day?
- IV fluids/ TPN
- Blood or blood products [should have a HCT as a reason]
- Oxygen needed? FiO2 and route? ABGs done or O2 sats?
- Diet / Tube feeds/ gavage [what is infant's weight]
- If patient is on a sliding scale, what were high/low glucose values? How many coverage units were given on each day [not the routine doses]?
- Wound management: describe wound and dressing/ debridement/ special issues
- Any other treatments or therapies?

DS [Discharge Screens] – What is the long–term plan?

- What is the expected destination after the hospitalization?
- What discharge planning activities are being done
- What care needs are there post–discharge? Educational needs?
- Are there significant psycho–social issues?

	Contact Number	Fax Number
Alaska Medicaid Pre–Service	800-783-9207	800-826-3630
Idaho Medicaid Pre–Service	800-783-9207	800-826-3836
L & I Pre–Service	800-541-2894	877-665-0383 206-366-3378
WA Teamsters Pre–Service	877-372-7861	206-368-2765
Private Insurance Pre–Service	800-783-8606	206-368-2765
L&I Physician Hotline	877–665–0382	
Medicaid / Private Physician Hotline	877–292–2615	

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Exhibit 5

Inpatient Review Worksheet

DATE:

Patient Name: _____ **ID #** _____
Attending name /contact info*/best time: _____

Admit Diagnosis/Code _____ **Procedure Code** _____

SI [SYMPTOM INTENSITY: CLINICAL ISSUES]

Review covers dates from _____ **to** _____
What is the main reason the patient is in the hospital for this day/days? _____

_____
_____
_____
_____
_____
_____

Please include a brief description of progress, diagnostic tests & results, consultations, evaluations:

_____
_____
_____
_____
_____

IS [INTENSITY OF SERVICES: TREATMENT]

IV medications & frequency:– & IV PRN meds [esp. pain] & # of times given per 24h

_____
_____
_____
_____

IV fluids/TPN/ lipids/ rates/bolus/ blood: _____
_____

Respiratory status/treatment _____
Nutritional status/treatment _____
Insulin coverage/ values: _____
Wound mgmt issues/frequency: _____
_____

Other treatments: _____
_____

DS [DC SCREENS]

Brief description of Discharge Planning : expected destination/ care needs/ educational needs

_____
_____
_____
_____
_____

* In case the attending needs to be called by a Qualis Health Medical Director.
Please identify a pager # or office number, and best time to call.

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Section VIII: Concurrent Review

A. Purpose

Concurrent review takes place during the time in which a client is confined to the facility. The purpose is to determine if the facility confinement and associated physician services are medically necessary and appropriate.

Qualis Health will perform concurrent review by telephone or FAX for DHW clients when one of the following situations occurs:

1. Pre–service review is **required** for the diagnosis/procedure; therefore, concurrent review will be done when the client's facility confinement reaches the review date assigned by Qualis Health at the time of the pre–service review ("scheduled discharge date") and when discharge on that day is unlikely.
2. Diagnoses/procedures **that do not require** pre–service review will be reviewed concurrently when the client's facility confinement reaches day four. **On day four, the admission is reviewed from the admission date.** Concurrent reviews will be done thereafter at intervals determined by Qualis Health.
3. **NOTE:** Effective September 1, 2003, the Department changed its policy regarding Cesarean Section deliveries. The new policy requires Qualis Health to conduct a review for medical necessity if the length of stay exceeds four (4) days or on day five (5) of inpatient stay for cases with dates of service on or after September 1, 2003. If the dates of service are prior to September 1, 2003, a review will be required if the client exceeds the day three (3) benchmark or on day four (4). Please refer to the August 2003 Information Release 2003–72 sent by the Department to Medicaid providers for a listing of ICD–9 Diagnostic Codes that will require review. See Appendix D for a copy of the Release.

B. Responsibility

The facility will be responsible for securing concurrent review back to the day of admission from Qualis Health when a DHW client's facility confinement reaches day four or the assigned review date.

C. Requirements

If the client is admitted with a diagnosis which does not require pre–service review and the diagnosis subsequently changes to one of the select diagnoses listed in Appendix A, providers will be required to call Qualis Health within one working day to obtain certification if a review has not been initiated.

If a concurrent review is in progress and a DHW client requires surgery for one of the selected procedures on the pre–authorization list, (refer to Appendix A) providers are required to call Qualis Health to obtain certification within one working day.

If a review has not been initiated with Qualis Health and post–admission the decision is made to perform a surgery on the pre–authorization list, the provider must call Qualis Health prior to the procedure if it is non–urgent or within one working day if the surgery is urgent.

REMINDER: Once a review has been initiated with Qualis Health, the review process will continue until one of the following occurs with the DHW client:

a) discharged
b) transferred to another facility
c) concurrent review is non–certified by Qualis Health
d) loss of Medicaid eligibility
e) becomes eligible for Medicare Part A after admission

D. Time Frames for UM Review Decisions

With all necessary clinical information received and no referral for clinical peer review, the timeframes are:

Review Type	Timeframes for Completion from Date of Notification to Qualis Health
Concurrent Review – Urgent*	Three calendar days
Concurrent Review – Non–Urgent	Three calendar days

When additional information is required to complete the review, the timeline is adjusted accordingly.

Qualis Health may choose to exercise a single extension of up to 15 calendar days on non–urgent reviews when there are reasons beyond the control of the organization that requires an extension. When this occurs, Qualis Health must inform the provider (by the date on which notice of the initial decision would normally be due) of the circumstances that require the extension and the date by which it expects to reach a decision. This single extension is only allowed on non–urgent reviews; it is not allowed for urgent care reviews.

***Definition of Case involving Urgent Care:** Any request for a utilization management determination with respect to which the application of the time periods for making non–urgent care determinations a) could seriously jeopardize the life or health of the client or the ability of the client to regain maximum function, or b) in the opinion of a physician with knowledge of the client's medical condition, would subject the client to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

E. Procedure

Concurrent review will be conducted on the toll–free line:

PHONE: 1-800-783-9207
FAX: 1-800-826-3836

Operational hours are as follows:

6:30 AM - 5:45 PM Pacific Time
7:30 AM - 6:45 PM Mountain Time
Monday through Friday

Refer to Exhibit 6 *Concurrent Review Flow Chart*, and Exhibit 7, *Concurrent Review Request FAX Form.*
Qualis Health intake representatives will collect the following basic information and verify Medicaid eligibility for those reviews requiring concurrent review:

1. Client name
2. Client birth date
3. Complete client address
4. Sex of client
5. Client I.D. number (Medicaid or FACS)
6. Admitting diagnosis and ICD–9–CM code
7. Physician name
8. Physician address
9. Physician phone number
10. Physician Medicaid provider number
11. Facility name
12. Facility address
13. Facility phone number
14. Facility Medicaid provider number
15. Current principal diagnosis and ICD–9–CM code
16. Procedure to be performed and ICD–9–CM code and/or CPT code
17. Justification for the hospitalization and/or client symptoms
18. Treatment proposed/provided
19. Admit date and/or surgery date
20. For review of newborns, the baby's weight in grams is required

NOTE: Changes to Qualis Health Neonatal Review Policy, effective April 2005:
Following the initial review, no further information will be needed until the infant reaches the 1st benchmark of 33 weeks gestation.

The Qualis Health nurse reviewer will review the information provided to assess the client's progress for the days being evaluated, the progress toward discharge and apply *InterQual® Criteria for Non–physician Review.* The Healthy Connections Primary Care Provider also will be notified (if the attending physician is not the primary care provider) by telephone of each new admission. If the screening criteria are met, the Qualis Health nurse reviewer will issue a Case ID number (if not previously obtained in a pre–service review) and the concurrent will be certified. The Qualis Health nurse reviewer will issue an approved length of stay including an assigned review date. Qualis Health nurse reviewers will follow the Qualis Health policy regarding referral to physician review. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

Qualis Health certification indicates only that the admission, procedure, or continued hospitalization is medically necessary. This certification does not guarantee payment of services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Idaho.
If the screening criteria are **not** met, the Qualis Health nurse reviewer will refer the case to a Qualis Health physician/practitioner consultant. The physician/practitioner consultant will review the clinical information and either certify the review or issue a potential non–

certification. In the event of a potential non–certification, the attending physician will be given an opportunity to speak with the Qualis Health physician/practitioner consultant. If a conference call is requested, the Qualis Health physician/practitioner consultant and the client's attending physician will discuss the treatment plan for the client as well as appropriate alternatives. Following the discussion, the Qualis Health physician/practitioner consultant will either certify or non–certify the stay.

If the physician/practitioner consultant certifies the stay, the Qualis Health nurse reviewer will issue a Case ID number and notify all appropriate parties.

F. Non–certifications

If the Qualis Health physician/practitioner consultant non–certifies all or part of the stay, a Qualis Health nurse reviewer will notify the facility utilization review department by telephone of the adverse determination. The utilization review coordinator will notify the client and attending physician in writing.

The letter issued by Qualis Health for the concurrent review non–certification will include the last date that Qualis Health certified the inpatient hospitalization (refer to the "scheduled discharge date") as well as justification for the decision. Non–certification letters will be sent within one working day to the following parties: the client, attending physician, facility QIO contact person, and the Department. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

NOTE: There are time constraints involved for potential non–certifications. The Qualis Health intake representative or nurse reviewer will notify the facility utilization review coordinator of the potential non–certification and request that the utilization review coordinator contact the attending physician to offer the option of a peer–to–peer discussion. At the same time, the Qualis Health physician/practitioner consultant will attempt to contact the attending physician to discuss the case further.

If a peer–to–peer conversation is desired by the attending physician, it is necessary to call Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time the day following notification of the potential non–certification. If the attending physician is not able to call within the stated time frame and an extension is desired, please notify Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time of the next business day.

If the case is non–certified after the peer–to–peer conversation, the stay will be non–certified retroactively to the day medical necessity was not met. If the **attending physician** does not call by 6:00 PM Mountain Time / 5:00 PM Pacific Time the following day, the case will be non–certified. The attending physician may use the physician "hotline," 1-877-292-2615, to discuss the client's case.

G. Appeals

Non–certification determinations for pre–service or concurrent reviews will be processed and subject to the same appeal reviews and appeal procedures. Refer to Section XX of this manual for a detailed description of the appeal procedure.

H. Administratively Necessary Days (ANDs)

Refer to Section XIX of this manual for a detailed description of the AND procedure.

Exhibit 6

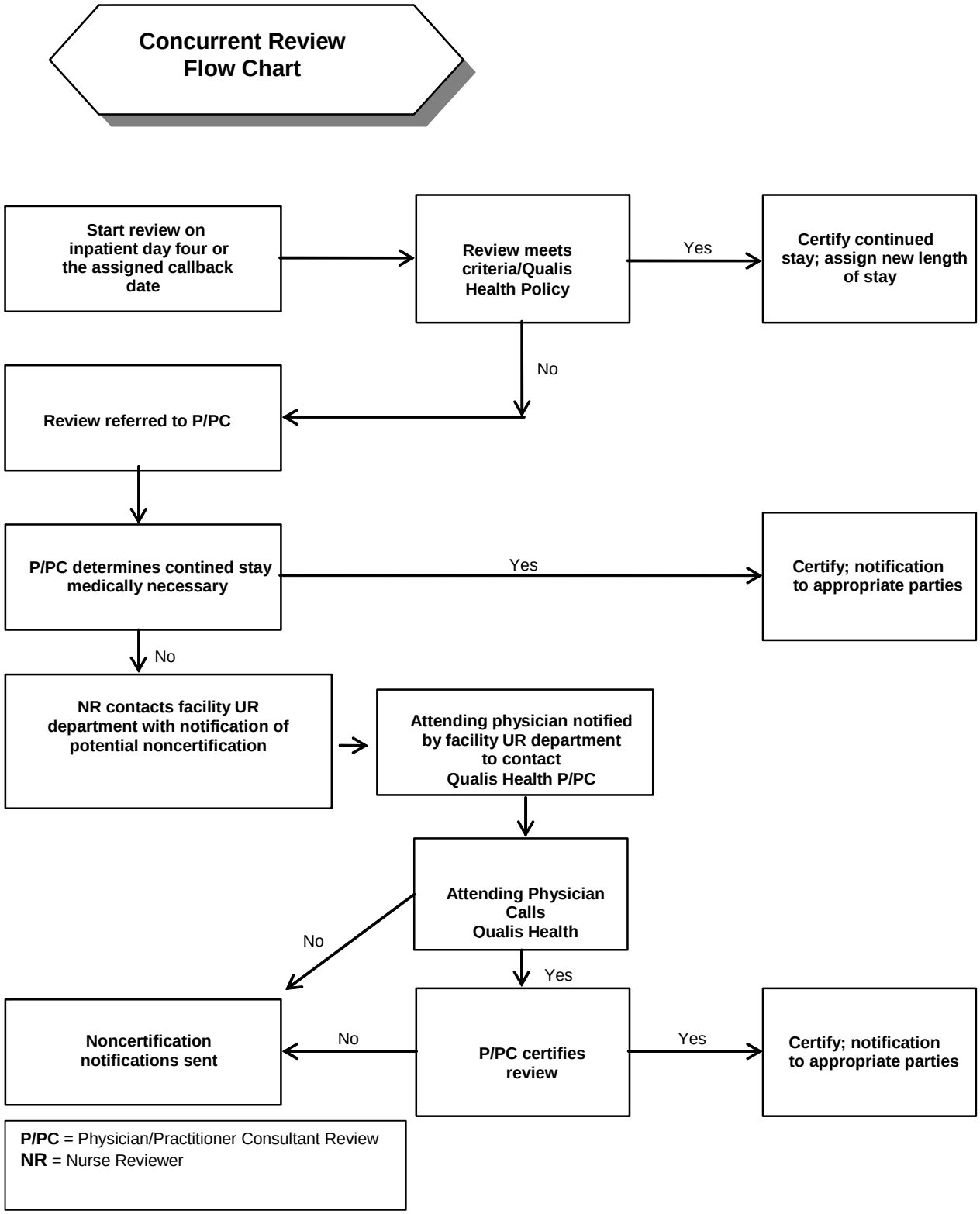
Concurrent Review Flow Chart
Start review on inpatient day four or the assigned callback date
Review meets criteria/Qualis Health Policy
Yes
Certify continued stay; assign new length of stay
No
Review referred to P/PC
P/PC determines contined stay medically necessary
Yes
Certify; notification to appropriate parties
No
NR contacts facility UR department with notification of potential noncertification
Attending physician notified by facility UR department to contact Qualis Health P/PC
Attending Physician Calls Oualis Health
No
Yes
Noncertification notifications sent
No
P/PC certifies review
Yes
Certify; notification to appropriate parties
P/PC = Physician/Practitioner Consultant Review
NR = Nurse Reviewer

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Exhibit 7

Concurrent Review Request FAX Form

Case ID #_____ Client's Name _____

Scheduled Call Back Date _____

Facility Reviewer's Name _____

Current Treatment Being Provided _____

Discharge Plan _____

Other Issues _____

Number of Days Requested _____

Qualis Health please call _____ or FAX _____ the review determination.

If Qualis Health has questions or needs additional information, contact _____

at _____

P.O. Box 33400 10700 Meridian Avenue North, Suite 100 ● Seattle, WA 98133 ● 1-800-783-9207; FAX: 1-800-826-3836

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Section IX: Late Certification Reviews

A. Purpose

Qualis Health has a procedure in place for accepting late reviews.

B. Definitions

For all admissions, late notifications are defined as follows:

1. Failure to obtain pre–service review for **non–urgent** admission and procedure on the list of select diagnoses and procedures requiring certification review (refer to Appendix A) at least **one working day prior** (preference is one week) to the procedure.
2. Failure to request certification for the admission when the DHW client's length of stay reaches day four of hospitalization and the client has not been discharged.
3. Failure to request certification for concurrent review on the assigned review date.
4. Failure to notify Qualis Health within one working day of an urgent admission or procedure which involves one of the select diagnoses or procedures on the pre–authorization list (refer to Appendix A). This includes urgent admissions that occur on a weekend or legal holiday.

C. Procedure

If the client has not been discharged, Qualis Health will accept requests for late reviews when one of the aforementioned situations occurs. The Qualis Health nurse reviewer will conduct the review as if the request were in accordance with the Idaho Medicaid Qualis Health review guidelines and policies. S/he will note the reason(s) for the late review request on the case.

Please complete the Qualis Health *Retrospective Review Request Form* (refer to Section XIV, Exhibit 14 of this manual) and **send** the following documentation to the Seattle Qualis Health office. Requests that are incomplete or not accompanied by the UB–92 and required reports **will not be processed and the facility will be notified the request is incomplete.**

- For a Medicaid client with a length of stay less than 15 days (excluding psychiatric cases under the age of 21), mail or fax: Retrospective Review Request Form, UB92, history and physical, discharge summary, and operative report (if applicable). Allow five (5) business days for processing before calling to complete the telephonic review.
- For a Medicaid client with a length of stay **15 days or more,** mail: Retrospective Review Request Form, UB92, and a complete legible copy of the entire medical record.
- For **any** admission for a client with a psychiatric diagnosis who is **under the age of 21,** mail: Retrospective Review Request Form, UB92, and a complete legible copy of the entire medical record.

Qualis Health will review the information and eligibility and determine whether the inpatient admission is medically necessary. If the Qualis Health nurse reviewer certifies the review, a Case ID number and length of stay will be issued. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

Qualis Health certification indicates only that the admission, procedure, or continued hospitalization is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Idaho.

The Department will be notified by Qualis Health of all late reviews. Idaho Medicaid will confirm the lack of timeliness of the review and issue a notice to the provider of the Department's intent to assess a late review penalty.

D. Penalty

Qualis Health does not have jurisdiction to reverse late review determinations involving late notifications issued by the Department of Health and Welfare. Please do not request an appeal from Qualis Health under these circumstances. It is necessary to direct these appeals to the Department.

E. Appeals

Late review determinations may be appealed by directing a written request to:

Department of Health and Welfare
Medicaid Financial Operations
P. O. Box 83720
Boise, ID 83720-0036
FAX: (208) 334-6515 or toll free (866) 852-2954
Phone: (208) 287-1152

Section X: Psychiatric and Chemical Dependency Review

1. Psychiatric Review: Clients Under the Age of 21

A. Purpose

Qualis Health will conduct pre–service and concurrent reviews of all admissions for individuals under the age of 21 with primary psychiatric diagnoses *with the exception of admissions to State Hospital South,* which are reviewed by the Department. Refer to the Select Pre–authorization List of Diagnoses and Procedures for Idaho Medicaid and Division of Family and Community Services Clients in Appendix A.

B. Responsibility

The attending physician is responsible for identification of Idaho Medicaid and Family and Community Services (FACS) admissions that require psychiatric review. When the attending physician has not obtained a pre–service review, this responsibility will fall to the admitting facility.

A sample copy of the *Psychiatric Admit Notification Information* Form is included in this section to assist in collecting the necessary information for review (refer to Exhibit 9). Qualis Health will start the review only when complete information has been received via FAX using this form.

FAX: 1-800-826-3836

C. Requirements

Effective January 1, 1998, rules were issued governing psychiatric hospital admissions for individuals under the age of 21. Subsequently, these rules were amended in March 2001. To obtain a copy of the current Medicaid rules, forward a request to the Idaho Department of Administration. Your request must include the name and location of the RULE: Rules Governing Medical Assistance, IDAPA 16.03.09.079–Inpatient Psychiatric Hospital Services. A copy can be requested from the following:

Idaho Department of Administration
Office of Administrative Rules
650 West State Street, Room 100
P.O. Box 83720
Boise ID 83720-0011

There is a copy charge of 10 cents per page. The entire section includes approximately 220 pages. The phone number for the Office of Administration is 208-334-3577.
The RULE also can be found on the Internet at:

http://www2.state.id.us/adm/adminrules/rules/idapa16/0309.pdf
(079. Inpatient Psychiatric Hospital Services)

or at any county clerk's office in the state of Idaho and many local libraries.

Idaho Medicaid requires pre–service review for psychiatric care. Idaho Medicaid reimburses for in–patient psychiatric services for an individual **under** the age of 21 in an institution for

mental disease or freestanding facility, as well as in a general hospital. **For clients under the FACS program, certification is required from the Division of Family and Community Services before a review may be done.**

Idaho Medicaid has developed special psychiatric criteria. These criteria must be used for all admissions on or after January 1, 1998 and include both Severity of Illness (SI) and Intensity of Services (IS).

Criteria for intensity of services require that the Regional Mental Health Authority (RMHA) document that less restrictive services are not available. Qualis Health encourages physicians and facilities to request and review these criteria. Individuals must have a DSM–IV diagnosis with substantial impairment in thought, mood, perception or behavior.

D. Procedure for Pre–service Review

Pre–service reviews will be conducted by FAX. Refer to Exhibit 9, *Psychiatric Admit Notification Information* Form.

Operational hours are as follows:

6:30 AM - 5:45 PM Pacific Time
7:30 AM - 6:45 PM Mountain Time
Monday through Friday

A pre–service review is required from Qualis Health prior to a non–urgent admission, which is defined as an admission that is planned and scheduled in advance, and is not urgent in nature, OR an urgent admission during regular business hours. Urgent admissions require authorization within one workday of the admission. An urgent (emergency) admission is defined as:

> **The sudden onset of acute psychiatric symptoms of such severity that the absence of immediate medical attention could reasonably be expected to result in serious dysfunction of any bodily organ/part or death of the individual or harm another person.**

The review submitted to Qualis Health should clearly document the necessity for urgent admission and must include the same information as required for non–urgent admissions. A hospital may request a concurrent review from Qualis Health, no later than the date assigned by Qualis Health or it will be considered a late review. The concurrent review must include documentation to support that treatment of the child's psychiatric condition continues to require services, which can only be provided on an in–patient basis.

Failure to request a pre–service or concurrent review from Qualis Health in a timely manner will result in the need to apply for a retrospective review by Qualis Health, and Qualis Health will notify the Department of the late review and a penalty may be assessed by the Department.

Qualis Health intake representatives will collect the following information, as outlined in the *Psychiatric Admit Notification Information Form*:

and verify Medicaid eligibility for those reviews requiring pre–service review:

1. Facility contact and phone number
2. Facility
3. Client name (with correct spelling)
4. Client DOB
5. Complete client address
6. Client phone number
7. Client I.D. number (Medicaid or FACS)
8. Phone (if different from above)
9. Custodial parent name, address & phone number (if different from above)
10. Name of person consenting to hospitalization
11. Relationship to client (address & phone number if different from above)
12. Admitting physician name, address & phone number
13. Primary care physician name, address & phone number
14. Healthy Connections primary care provider, if applicable, Healthy Connections referral number.
15. Diagnoses and ICD–9 codes

The *Psychiatric Admit Notification Information Form* needs to be completed.

When the forms are received, the Qualis Health intake representative will forward the clinical information to the appropriate RMHA representative, who will review this information and decide whether services in a less restrictive setting are available. At the same time, the Qualis Health nurse reviewer will review the information provided and apply the criteria that are published in the Medicaid rules. If the RMHA determines that less restrictive services are not available, the RMHA will notify Qualis Health and Qualis Health may certify the review. The Qualis Health nurse reviewer will issue an approved length of stay including an assigned review date. Qualis Health nurse reviewers will follow the Qualis Health policy regarding referral to physician review. When less restrictive services do exist, Qualis Health must non–certify the request. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

Qualis Health certification indicates only that the admission is medically necessary. This certification does not guarantee payment of services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Idaho.

If criteria for severity of illness and intensity of services are NOT met, the nurse reviewer will refer the review to a Qualis Health physician/practitioner consultant. The physician/practitioner consultant will review the clinical information and either certify the review or issue a potential non–certification. In the event of a potential non–certification, the attending physician will be given an opportunity to speak with the Qualis Health physician/practitioner consultant. If a conference call is requested, the Qualis Health physician/practitioner consultant and the client's attending physician will discuss the treatment plan for the client as well as appropriate

alternatives. Following the discussion, the Qualis Health physician/practitioner consultant will either certify or non–certify the stay.

If the physician/practitioner consultant certifies the stay, the Qualis Health nurse reviewer will issue a Case ID Number and notify all appropriate parties.

E. Procedure for Concurrent Review

The facility review department is responsible for securing concurrent reviews from Qualis Health on the assigned review date (scheduled discharge date). The initial Case ID number issued for pre–service psychiatric reviews is required before certification for the concurrent can be granted.

The focus of concurrent review is to address intensity of service and to assure that discharge plans are be formulated.

If criteria for severity of illness and intensity of services are NOT met, the nurse reviewer will refer the review to a Qualis Health physician/practitioner consultant. The physician/practitioner consultant will review the clinical information and either certify the review or issue a potential non–certification. In the event of a potential non–certification, the attending physician will be given an opportunity to speak with the Qualis Health physician/practitioner consultant. If a conference call is requested, the Qualis Health physician/practitioner consultant and the client's attending physician will discuss the treatment plan for the client as well as appropriate alternatives. Following the discussion, the Qualis Health physician/practitioner consultant will either certify or non–certify the stay.

If the Qualis Health physician/practitioner consultant certifies the stay, a call back date will be issued to the facility. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

Qualis Health certification indicates only that the continued hospitalization is medically necessary. This certification does not guarantee payment for services. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Idaho.

F. Non–certifications

If the Qualis Health physician/practitioner consultant non–certifies the review (due to a lack of medical necessity), Qualis Health will notify the RMHA, attending physician or facility by telephone and will send non–certification letters within one business day to the client, attending physician, facility and the Department.

When the RMHA determines that less restrictive services are available, Qualis Health will issue a technical denial and notify the physician, client and/or family. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer. Please note that all technical denials will be appealed to the Department and not Qualis Health.**

If the Qualis Health physician/practitioner consultant non–certifies the stay, a Qualis Health nurse reviewer will notify the facility utilization review department by telephone of the adverse

determination. The utilization review coordinator will notify the client and attending physician in writing. Acknowledgment of this letter requires the client's signature.

The letter issued by Qualis Health for the concurrent non–certification will include the last date that Qualis Health certified the inpatient hospitalization (refer to the "scheduled discharge date") as well as justification for the decision. Non–certification notifications will be sent within one working day to the following parties: the client, attending physician, facility QIO contact person, and the Department. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

NOTE: There are time constraints involved for potential non–certifications. The Qualis Health intake representative or nurse reviewer will notify the facility utilization review coordinator of the potential non–certification and request that the utilization review coordinator contact the attending physician to offer the option of a peer–to–peer discussion. At the same time, the Qualis Health physician/practitioner consultant will attempt to contact the attending physician to discuss the case further.

If a peer–to–peer conversation is desired by the attending physician, it is necessary to call Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time the day following notification of the potential non–certification. If the attending physician is not able to call within the stated time frame and an extension is desired, please notify Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time of the next business day.

If the case is non–certified after the peer–to–peer conversation, the stay will be non–certified retroactively to the day medical necessity was not met. If the **attending physician** does not call by 6:00 PM Mountain Time / 5:00 PM Pacific Time the following day, the case will be non–certified. The attending physician may use the physician "hotline," 1-877-292-2615, to discuss the client's case.

G. Appeals

Non–certification determinations for pre–service review or concurrent reviews will be processed and subject to the same appeal reviews and appeal procedures. Refer to Section XX of this manual for a detailed description of the appeal procedure.

H. Administratively Necessary Days (ANDs)

Refer to Section XIX of this manual for a detailed description of the AND procedure.

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Exhibit 8

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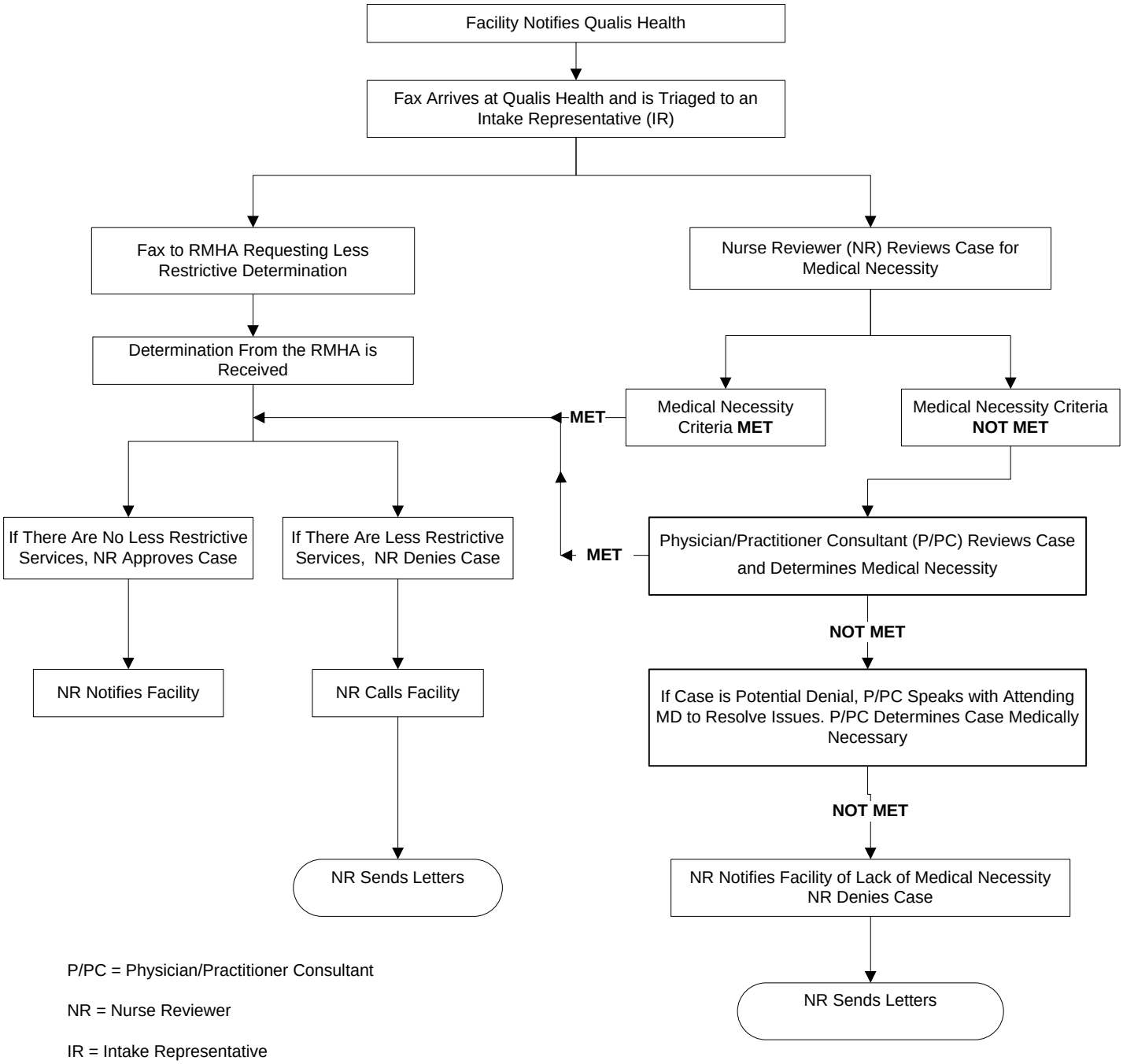
Psychiatric Review Flow Chart < 21 years



P/PC = Physician/Practitioner Consultant

NR = Nurse Reviewer

IR = Intake Representative

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Exhibit 9

PSYCHIATRIC ADMIT NOTIFICATION INFORMATION
(For Individuals Under the Age of 21)
(Please fill out completely)

Return to Qualis Health by FAX 1-800-826-3836

Facility Contact: _____ Facility: _____

Client Name: _____ DOB: _____ M/F: _____

Client Address, County, Zip Code: _____

_____

_____

Client Phone Number: _____ Medicaid #: _____

Admit Time/Date: _____ Urgent or Non–urgent Admit: _____

Client Grade In School _____ Client School: _____

Parent(s) or Guardian(s) Name(s) _____

Address (if different from above _____

Phone (if different from above) _____

Custodial Parent Name, Address & Phone Number (if different from above):

_____

_____

Name of Person Consenting to Hospitalization _____

Relationship to Client (address and phone number if different from above):

_____

_____

Admitting Physician's Name: _____

Admitting Physician's Address and Phone Number:

_____

_____

Name, Address and Phone Number of Primary Care Physician (if different from above):

_____

Member of Healthy Connections: Yes Yes No____

Health Connection Referral: Yes_____ No_____

Diagnosis and Codes:

_____

_____

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Exhibit 9 (continued)

Client Name:_____

PSYCHIATRIC HOSPITAL REVIEW DOCUMENTATION REQUIREMENTS (For Individuals Under the Age of 21)

1) Summary of present medical findings occurring within the last 24–72 hours, including symptoms, complaints, and complications indicating need for admission. Include the recent circumstances of this admission and be specific regarding the time frames of the episode. Also drug/alcohol history and testing.

2) Recent or current history of suspected physical or sexual abuse to the client or by the client
If yes, please submit the following information:
Reported by physician or facility to Children's Protective Services (CPS)? Yes No
Name of individual who filed the report
Date the report was filed

3) Treatment history including prior out of home placements, hospitalization, in–home services, individualized education plan (IEP) through the child's school. Indicate if this is the first psychiatric inpatient admission. Also include current outpatient medications.

4) Mental and physical capacity including domains in which the child or young adult is experiencing substantial impairment, i.e., home, school, community, or with peers.

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Exhibit 9 (continued)

Client Name:_____

5) Specify the providers and/or individuals that are currently involved with this child or young adult and his/her family on an outpatient basis, if any.

6) Family resources, i.e., employment, cash assistance, SSI, and private insurance when available (referring physician or facility should have this information). Specify whether one or both parents live in the home.

7) Treatment plan: include information such as psychological testing, labs, medications, groups, role playing, school, precautions, seclusion, etc.

8) Discharge plan: indicate outpatient therapy anticipated. Include what, with whom, how long.

9) Prognosis:

10) Estimated length of stay:

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2. Chemical Dependency Review: Clients Under the Age of 21

A. Purpose

Qualis Health will conduct pre–service and concurrent reviews of all admissions for detoxification and chemical dependency treatment with diagnoses included on the select pre–authorization list in Appendix A for clients under the age of 21.

B. Responsibility

The facility Utilization Review Department is responsible for identification of Medicaid admissions that require review.

The client's attending physician is ultimately responsible for obtaining certification of selected admissions; however, Qualis Health also will accept telephone calls from the facility utilization review department, especially for urgent admissions.

C. Requirements

Approval is required from the Division of Family and Community Services (FACS) before a review may be done for clients enrolled in the FACS program.

D. Procedure for Pre–service Review

Pre–service reviews will be conducted telephonically on the toll–free line:

1-800-783-9207

Operational hours are as follows:

6:30 AM – 5:45 PM Pacific Time
7:30 AM – 6:45 PM Mountain Time
Monday through Friday

Qualis Health intake representatives will collect the following information and verify Medicaid eligibility for those reviews requiring pre–service review:

1. Client name (with the correct spelling)
2. Client birth date
3. Complete client address
4. Sex of client
5. Client I.D. number (Medicaid or FACS)
6. Admitting diagnosis and ICD–9–CM code
7. Physician name
8. Physician address
9. Physician phone number

10. Physician Medicaid provider number
11. Facility name
12. Facility address
13. Facility phone number
14. Facility Medicaid provider number
15. Current principal diagnosis and ICD–9–CM code
16. Justification for the hospitalization and/or client symptoms
17. Treatment proposed/provided
18. Admission date

The Qualis Health nurse reviewer will review the clinical information provided and apply *InterQual® Criteria for Non–physician Review.* If the screening criteria are met, the Qualis Health nurse reviewer will issue an authorization number. **The length of stay will be assigned based on the specific disorder, past medical and psychiatric history, and individual treatment needs.** Qualis Health nurse reviewers will follow the Qualis Health policy regarding referral to physician review. Notification will be made to all appropriate parties, including the Healthy Connections primary care provider, if applicable. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

Qualis Health certification only indicates that the admission is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Idaho.

If the screening criteria are **not** met, the Qualis Health nurse reviewer will refer the review to a Qualis Health physician/practitioner consultant. The Qualis Health physician/practitioner consultant will review the clinical information and either certify the admission or issue a potential non–certification. The attending physician is given an opportunity to speak with the Qualis Health physician/practitioner consultant. During this conference call, the Qualis Health physician/practitioner consultant and the client's attending physician will discuss the treatment plan as well as appropriate alternatives. Following the discussion, the Qualis Health physician/practitioner consultant will either certify or non–certify the admission.

If the Qualis Health physician/practitioner consultant certifies the admission, the Qualis Health nurse reviewer will issue a Case ID number and length of stay, and all appropriate parties will be notified. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

E. Procedure for Concurrent Review

The facility utilization review department is responsible for securing concurrent reviews from Qualis Health on the assigned review date. The initial Case ID number issued for pre–service review is required before concurrent reviews can be granted.

The focus of concurrent review is to address treatment provided and/or parameters for discharge.

The review will be certified if the justification and treatment provided meet the screening criteria. The Qualis Health nurse reviewer will issue a continued length of stay including the call back date. If the review does not meet screening criteria, or if the nurse reviewer questions the need for concurrent, the review will be referred to a Qualis Health physician/practitioner consultant.

The Qualis Health physician/practitioner consultant may certify the continued length of stay or issue a potential non–certification. The attending physician is given an opportunity to speak with the Qualis Health physician/practitioner consultant. After speaking with the client's attending physician, the Qualis Health physician/practitioner consultant will either recertify or non–certify the concurrent.

If the Qualis Health physician/practitioner consultant certifies the stay, a call back date will be issued to the facility. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

Qualis Health certification only indicates that the continued hospitalization is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Idaho.

F. Non–certifications

If the Qualis Health physician/practitioner consultant non–certifies the admission or concurrent hospitalization, the Qualis Health nurse reviewer will notify the appropriate provider (e.g., attending physician/facility) by telephone of the adverse determination. Qualis Health will send non–certification notification within one working day to the following parties: client or client representative, attending physician, facility QIO contact person and the Department. The letter issued by Qualis Health will include the last date that Qualis Health certified the hospitalization (refer to the "scheduled discharge date"), as well as justification for the decision. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

The non–certification notification will contain an explanation of the right to request an appeal of Qualis Health's initial non–certification determination, as well as rationale for the decision. Refer to Section XX of this manual for a detailed description of the appeal procedure.

NOTE: There are time constraints involved for potential non–certifications. The Qualis Health nurse reviewer will notify the facility utilization review coordinator of the potential non–certification and request that the utilization review coordinator contact the attending physician to offer the option of a peer–to–peer discussion. At the same time, the Qualis Health

physician/practitioner consultant will attempt to contact the attending physician to discuss the case further.

If a peer–to–peer conversation is desired by the attending physician, it is necessary to call Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time the day following notification of the potential non–certification. If the attending physician is not able to call within the stated time frame and an extension is desired, please notify Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time of the next business day.

If the case is non–certified after the peer–to–peer conversation, the stay will be non–certified retroactively to the day medical necessity was not met. If the **attending physician** does not call by 6:00 PM Mountain Time / 5:00 PM Pacific Time the following day, the case will be non–certified. The attending physician may use the physician "hotline," 1-877-292-2615, to discuss the client's case.

G. Appeals

Non–certification determinations for pre–service or concurrent reviews will be processed and subject to the same appeal reviews and appeal procedures. Refer to Section XX of this manual for a detailed description of the appeal procedure.

H. Administratively Necessary Days (ANDs)

Refer to Section XIX of this manual for detailed description of the AND procedure.

3. Psychiatric/Chemical Dependency Review: Clients 21 years of Age or Older

A. Purpose

Qualis Health will conduct pre–service and concurrent reviews of all admissions for psychiatric diagnoses included on the select pre–authorization list in Appendix A for clients who are 21 years of age or older.

B. Responsibility

The facility Utilization Review Department is responsible for identification of Medicaid admissions that require psychiatric review.

A sample copy of the *Psychiatric Worksheet for Pre–service Review* and *Psychiatric Worksheet for Concurrent Review* are included in this section to assist in collecting the necessary information for review. (Refer to Exhibits 11 and 12).

The client's attending physician is ultimately responsible for obtaining certification of inpatient psychiatric admissions; however, Qualis Health will also accept telephone calls from the facility utilization review department, especially for urgent psychiatric admissions.

C. Requirements

Qualis Health pre–service review is not required for clients who are admitted to free–standing inpatient psychiatric facilities and who are 21 years of age or older. Idaho Medicaid does not cover admissions in these facilities for this age group.

D. Procedure for Pre–service Review

Pre–service reviews will be conducted telephonically on the toll–free line:

1-800-783-9207

Operational hours are as follows:

6:30 AM – 5:45 PM Pacific Time
7:30 AM – 6:45 PM Mountain Time
Monday through Friday

Qualis Health intake representatives will collect the following information and verify Medicaid eligibility for those reviews requiring pre–service review:

1. Client name (with the correct spelling)
2. Client birth date
3. Complete client address
4. Sex of client
5. Client I.D. number (Medicaid or FACS)

6. Admitting diagnosis and ICD–9–CM code
7. Physician name
8. Physician address
9. Physician phone number
10. Physician Medicaid provider number
11. Facility name
12. Facility address
13. Facility phone number
14. Facility Medicaid provider number
15. Current principal diagnosis and ICD–9–CM code
16. Justification for the hospitalization and/or client symptoms
17. Treatment proposed/provided
18. Admit date and/or surgery date

The Qualis Health nurse reviewer will review the information provided and apply *InterQual® Criteria for Non–physician Review*. If the screening criteria are met, the Qualis Health nurse reviewer will issue a Case ID number. **The length of stay will be assigned based on the specific psychiatric disorder, past medical and psychiatric history, and individual treatment needs**. Qualis Health nurse reviewers will follow the Qualis Health policy regarding referral to physician review. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

Qualis Health certification indicates only that the admission is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern medical assistance in Idaho.

If the screening criteria are **not** met, the Qualis Health nurse reviewer will refer the case to a Qualis Health physician/practitioner consultant. The Qualis Health physician/practitioner consultant will review the clinical information and either certify the admission or issue a potential non–certification. The attending physician is given an opportunity to speak with the Qualis Health physician/practitioner consultant. During this conference call, the Qualis Health physician/practitioner consultant and the client's attending physician will discuss the treatment plan as well as appropriate alternatives. Following the discussion, the Qualis Health physician/practitioner consultant will either certify or non–certify the admission.

If the Qualis Health physician/practitioner consultant certifies the admission, the Qualis Health nurse reviewer will issue a Case ID number and length of stay and notify all appropriate parties as listed above, including the client's Healthy Connections primary care provider, if applicable. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

E. Procedure for Concurrent Review

The facility utilization review department is responsible for securing concurrent reviews from Qualis Health on the assigned review date. The initial Case ID number issued for pre–service reviews is required before a continued length of stay can be granted.

The focus of concurrent reviews is to address intensity of services and/or parameters of discharge.

The review will be certified if the justification and treatment provided meet the Qualis Health screening criteria. The Qualis Health nurse reviewer will issue a continued length of stay including the call back date. If the review does not meet screening criteria, or if the nurse reviewer questions the need for concurrent, the review will be referred to a Qualis Health physician/practitioner consultant.

The Qualis Health physician/practitioner consultant may certify the stay or issue a potential non–certification. The attending physician is given an opportunity to speak with the Qualis Health physician/practitioner consultant. After speaking with the client's attending physician, the Qualis Health physician/practitioner consultant will either certify or non–certify the concurrent.

If the Qualis Health physician/practitioner consultant certifies the stay, a call back date will be issued to the facility. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

Qualis Health certification indicates only that the continued hospitalization is medically necessary. The certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Idaho.

F. Non–certifications

If the Qualis Health physician/practitioner consultant non–certifies the ***admission***, a Qualis Health nurse reviewer will notify the appropriate provider (e.g., attending physician/facility) by telephone. Qualis Health will send non–certification notification within one working day to the following parties: the client, attending physician, facility QIO contact person and the Department. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

The non–certification notification will contain an explanation of the right to request an appeal of Qualis Health's initial non–certification determination, as well as justification for the decision. Refer to Section XX of this manual for a detailed description of the appeal procedure.

If the Qualis Health physician/practitioner consultant non–certifies the ***continuation of the stay***, the Qualis Health nurse reviewer will notify the facility utilization review department by telephone of the adverse determination. The utilization review coordinator will then notify the client and attending physician in writing. Acknowledgment of this letter requires the Medicaid client's signature.

The letter issued by Qualis Health for the non–certified stay will include the last date that Qualis Health certified the hospitalization (refer to the "scheduled discharge date"), as well as justification for the decision. Non–certification notification will be sent within one working day to the following parties: the client, attending physician, facility QIO contact person, and the Department. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

The non–certification notification will contain an explanation of the right to request an appeal of Qualis Health's initial non–certification determination. Refer to Section Section XX of this manual for a detailed description of the appeal procedure.

NOTE: There are time constraints involved for potential non–certifications. The Qualis Health nurse reviewer will notify the facility utilization review coordinator of the potential non–certification and request that the utilization review coordinator contact the attending physician to offer the option of a peer–to–peer discussion. At the same time, the Qualis Health physician/practitioner consultant will attempt to contact the attending physician to discuss the case further.

If a peer–to–peer conversation is desired by the attending physician, it is necessary to call Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time the day following notification of the potential non–certification. If the attending physician is not able to call within the stated time frame and an extension is desired, please notify Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time of the next business day.

If the case is non–certified after the peer–to–peer conversation, the stay will be non–certified retroactively to the day medical necessity was not met. If the **attending physician** does not call by 6:00 PM Mountain Time / 5:00 PM Pacific Time the following day, the case will be non–certified. The attending physician may use the physician "hotline," 1-877-292-2615, to discuss the client's case.

G. Appeals

Non–certification determinations for pre–service review or concurrent reviews will be processed and subject to the same appeal reviews and appeal procedures. Refer to Section XX of this manual for a detailed description of the appeal procedure.

H. Administratively Necessary Days (ANDs)

Refer to Section XIX of this manual for detailed description of the AND procedure.

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Exhibit 10

Psychiatric Worksheet for Pre–service Review (Clients 21 Years or Older)

Your Name: _____ Tel #: _____ FAX #: _____

Today's Date: _____ Facility: _____

Client's Name: _____ Sex _____ DOB: _____ Age _____

Client's Address: _____

Medicaid #: _____ Admit Date _____

Urgent: _____ Non–urgent _____

Number of Days Requested: _____ Would you like reply by phone or FAX? _____

Chief complaint, presenting problem, symptoms, precipitating event _____

_____

_____

_____

Past inpatient history; outpatient history, including approximate dates for most recent care.

Outpatient medications: _____

_____

Concurrent medical diagnosis affecting psychiatric condition: _____

_____

Substance use/abuse, issues: _____

_____

Legal charges, issues: _____

_____

Family & social history, school (brief summary): _____

_____

History of physical/sexual abuse (when, for how long, has it been reported?) _____

_____

Mental status (thought content, thought disorder, mood, affect; behaviors): _____

Exhibit 10 (continued)

Is intellectual deficit suspected? _____

Comments: _____

_____

_____

Treatment plan, precautions, testing ordered (detailed): _____

_____

_____

_____

Estimated length of stay, discharge plan with follow–up: _____

_____

Other pertinent information: _____

_____

_____

_____

Questions/issues for next review: _____

_____

_____

_____

_____

_____

Diagnosis Description: _____ *Code(s):* _____

_____ _____

_____ _____

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Exhibit 11

Psychiatric Review Worksheet for Concurrent Review (All Ages)

Your Name: _____ Tel #: _____ FAX # _____

Today's Date _____ Facility _____

Client's Name _____

Client's Address: _____

_____

_____

Medicaid #: _____ Admit Date _____ Reference #: _____

Number of Days Requested _____ Would you like reply by phone or FAX? _____

Anticipated DC date, plan, follow–up: _____

_____

Address questions from last review: _____

_____

_____

Medication orders, changes, levels: _____

_____

_____

Precautions, level changes: _____

_____

Test results: _____

_____

Names of groups (first concurrent): _____

_____

_____

Inpatient necessity (behaviors; unit and school performance): _____

_____

_____

Exhibit 11 (continued)

Mental status (mood, affect, thought disorders): _____

Participation, investment, insight: _____

Progress towards stabilization/benefit from treatment: _____

Treatment plan: _____

Family (or equivalent) involvement; appropriate discharge preparation: _____

Other pertinent information: _____

Information needed (next review): _____

Section XI: Physical Rehabilitation Review

A. Purpose

Review organizations have found that the most effective form of review takes place before the client enters the rehabilitation facility. The chief advantage is that inappropriate rehabilitation stays can be avoided rather than contested after expenses are incurred.

B. Responsibility

The facility utilization review department is responsible for the identification of Medicaid and FACS cases that require physical rehabilitation review.

The attending physician is ultimately responsible for obtaining certification of inpatient physical rehabilitation admissions; however, Qualis Health also will accept telephone calls from the facility utilization review department.

C. Requirements

All physical rehabilitation services must be provided in State–certified or Medicare–approved rehabilitation units.

D. Procedure for Pre–service Review

Pre–service reviews will be conducted on the toll–free line:

1-800-783-9207

Operational hours are as follows:

6:30 AM - 5:45 PM Pacific Time
7:30 AM - 6:45 PM Mountain Time
Monday through Friday

Pre–service Review for Rehabilitation has two components:

1. Assessment of a client's rehabilitation potential

   Before a client is admitted to the rehabilitation facility or unit specifically for rehabilitative care, an assessment is made of his/her:

   a) Medical condition and history
   b) Functional limitations
   c) Prognosis
   d) Possible need for corrective surgery
   e) Attitude toward rehabilitation
   f) Ability to learn, meet rehabilitation goals and participate in 3 hours of therapy 5 days per week
   g) The existence of any social problems affecting rehabilitation
   h) Expected outcome(s) from rehabilitation treatment

Reasonable rehabilitation goals should be identified for Qualis Health evaluation. The plan of care should include short and long term goals.

2. Evaluation of Rehabilitation Program

   Evaluation of the weekly multi–disciplinary rehabilitation team documentation will be reviewed during the next scheduled concurrent review.

   a) Physical, occupational, and/or speech therapy that total three hours per day, five days per week. (Medical reasons or complications precluding this criterion must be documented.)
   b) Any of the following services as indicated:
      i. Medical/social services
      ii. Psychology
      iii. Recreational therapy
      iv. Vocational counseling
   c) Skilled rehabilitative nursing care or supervision required and available on a 24–hour basis.
   d) Documentation of measurable weekly improvement in any functional ability in at least one therapy, and revision of goals if necessary.

The pre–service review may be conducted by the rehabilitation facility (i.e., physician or staff). It is recommended that the call is initiated at least one week prior to a planned rehabilitation admission or preferably as soon as admission to a rehabilitation unit is anticipated.

A sample copy of the *Physical Rehabilitation Review Worksheet for Pre–service Review* is included in this section to assist in collecting the necessary information for review (refer to Exhibit 13).

The Qualis Health intake representative will collect the following information and verify Medicaid eligibility for those reviews requiring pre–service review:

1. Client name (with the correct spelling) and address
2. Client birth date
3. Complete client address
4. Sex of Client
5. Client I.D. number (Medicaid or FACS)
6. Admitting diagnosis and ICD–9–CM code
7. Physician name
8. Physician address
9. Physician phone number
10. Physician Medicaid provider number
11. Facility name
12. Facility address
13. Facility Medicaid provider number
14. Current principal diagnosis and ICD–9–CM code
15. Relevant surgeries and ICD–9–CM or CPT codes
16. Justification for the hospitalization and/or client symptoms

17. Treatment proposed/provided
18. Admission date

The Qualis Health nurse reviewer will review the information provided and apply *InterQual® Criteria for Non–physician Review*. The nurse reviewer will assign a Case ID number and length of stay when the criteria are met. Qualis Health nurse reviewers will follow the Qualis Health policy regarding referral to physician review. This will establish the date that a concurrent review will be conducted if the client has not been discharged. Physical rehabilitation reviews usually are conducted on a weekly basis to coincide with the weekly team conferences. The client's Healthy Connections primary care provider also will be notified of the certified admission, if applicable. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

Qualis Health certification indicates only that the admission is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Idaho.

If the screening criteria are not met, the Qualis Health nurse reviewer will refer the review to a Qualis Health physician/practitioner consultant. The Qualis Health physician/practitioner consultant will review the clinical information and either certify the admission or issue a potential non–certification. In the event of a potential non–certification, the client's attending physician is given the opportunity to speak with the Qualis Health physician/practitioner consultant. During this conference call, the Qualis Health physician/practitioner consultant and the client's attending physician will discuss the treatment plan as well as appropriate alternatives. Following this discussion, the Qualis Health physician/practitioner consultant will either certify or non–certify the admission.

If the Qualis Health physician/practitioner consultant certifies the admission, a Qualis Health nurse reviewer will issue a Case ID number and assign a length of stay. The nurse reviewer will notify all appropriate parties, including the Healthy Connections primary care provider, if applicable.

E. Procedure for Concurrent Review

The initial Case ID number issued is required before concurrent for the continuation of the stay can be granted. The physician and/or utilization review department of the rehabilitation facility is responsible for securing concurrent review from Qualis Health when the assigned review date has been reached.

Concurrent review will be conducted on the same toll–free line:

1-800-783-9207

Operational hours are as follows:

6:30 AM – 5:45 PM Pacific Time
7:30 AM – 6:45 PM Mountain Time
Monday through Friday

Please refer to Exhibit 14 in this section for a sample of *Physical Rehabilitation Review Worksheet for Concurrent Review*. The focus of concurrent review is to address the intensity of the treatment provided and the progress of the patient.

The stay will be certified if the justification and treatment provided meet Qualis Health's screening criteria. Qualis Health nurse reviewers will follow the Qualis Health policy regarding referral to physician review. A date to call back will be issued at the time of the review. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

Qualis Health certification indicates only that the continued hospitalization is medically necessary. The certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Idaho.

F. Non–certifications

If the review does not meet criteria, it will be referred to a Qualis Health physician/practitioner consultant for review. The physician/practitioner consultant may issue a potential non–certification. A Qualis Health nurse reviewer will notify the facility utilization review department of a potential non–certification and request the utilization review coordinator to notify the client's attending physician. In the event of a potential non–certification, the attending physician is given the opportunity to speak with the Qualis Health physician/practitioner consultant. If the Qualis Health physician/practitioner consultant non–certifies the stay, the Qualis Health nurse reviewer will notify the facility utilization review department by telephone of the adverse determination. The utilization review coordinator will then notify the client and attending physician in writing. Acknowledgment of this letter requires the client's signature.

The letter issued by Qualis Health for the non–certified stay will include the last date that Qualis Health certified the inpatient hospitalization (refer to the "scheduled discharge date"), as well as the rationale for the decision. Non–certification notification will be sent within one working day to the following parties: client, attending physician, facility QIO contact person, and the Department. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

The non–certification notification will contain an explanation of the right to request an appeal of Qualis Health's initial non–certification determination. Refer to Section XX of this manual for a detailed description of the appeal procedure.

NOTE: There are time constraints involved for potential non–certifications. The Qualis Health nurse reviewer will notify the facility utilization review coordinator of the potential non–certification and request that the utilization review coordinator contact the attending physician to offer the option of a peer–to–peer discussion. At the same time, the Qualis Health physician/practitioner consultant will attempt to contact the attending physician to discuss the case further.

If a peer–to–peer conversation is desired by the attending physician, it is necessary to call Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time the day following notification of the potential non–certification. If the attending physician is not able to call within the stated time frame and an extension is desired, please notify Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time of the next business days.

If the case is non–certified after the peer–to–peer conversation, the stay will be non–certified retroactively to the day medical necessity was not met. If the **attending physician** does not call by 6:00 PM Mountain Time / 5:00 PM Pacific Time the following day, the case will be non–certified. The attending physician may use the physician "hotline," 1-877-292-2615, to discuss the client's case.

G. Appeals

Refer to Section XX of this manual for a detailed description of the Appeal procedure.

H. Administratively Necessary Days (ANDs)

Refer to Section XIX of this manual for a detailed description of the AND procedure.

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Exhibit 12

Physical Rehabilitation Review Worksheet
For
Pre–service Review

Initial Call Date: _____ Caller's Name: _____ Phone: _____

Planned Rehabilitation Admission Date: _____

Client's Name: _____

Client's Address: _____

_____

Birth Date: _____ Sex: _____

Medicaid ID Number: _____

Rehabilitation Facility: _____ Location: _____

Current Physician Name: _____ Physician ID #: _____ Phone #_____

Proposed Rehabilitation Physician: _____ Physician ID #: _____ Phone #_____

Phone: _____ Address: _____ City_____ State_____ Zip_____

ICD–9–CM Code(s): _____

and written description _____

_____

_____

_____

_____

Relevant Surgery Codes:

_____

Severity of Illness

What is the illness/injury/surgery or exacerbation that has occurred within the last 30 days?_____

_____

What is the mobility, ADL or respiratory impairment requiring at least minimum assistance? _____

_____

Exhibit 12 (continued)

Client's Name: _____

Severity of Illness (continued)

Is the client clinically stable within the last 24 hours? Please provide the temperature, heart rate, respiratory rate and BP from the last 24 hours. _____

_____

Is the client able to tolerate the comprehensive rehabilitation program of 3 hours/day or longer of skilled therapy for 5 days or greater a week? _____

_____

Is the client able to follow visual/verbal commands?_____

_____

Does the client desire and able to actively participate? _____

_____

Is the client active in the community and home prior to admission with rehabilitation potential? _____

_____

Is the client fully participating in the therapeutic evaluation and interventions prior to transfer? _____

_____

Is the admission a trial admission for 1 week or less? _____

_____

Is the prospective assessment completed by a rehabilitation professional? _____

_____

Is full participation/tolerance projected? _____

_____

What therapies are indicated? _____

_____

Is the treatment precluded in a lower level of care due to the clinical complexity? _____

_____

Exhibit 12 (continued)

Client's Name: _____

Severity of Illness (continued)

Will the physician do an assessment/intervention 3 times/week or greater? _____

_____

Is there specialized therapeutic skills/equipment required? If so, please identify? _____

_____

Will the rehabilitation nursing services be available 24 hours/day? _____

_____

Intensity of Service

Will The Progressive Therapy Program consist of at least 2 disciplines and 3 hours/day or greater and 5 days/week for:_____

_____

_____ ADLs
_____ Bed mobility/Transfers
_____ Home Lifestyle modifications
_____ Positioning/Splinting
_____ Pulmonary rehabilitation
_____ ROM/Strengthening
_____ Speech language retraining
_____ Swallowing retraining
_____ Wheelchair mobility/Ambulation/Balance

If this is an admission trial of 1 week or less, the program will provide:

_____At least 2 disciplines and 3 hours/day or greater and 5 days/week or greater of evaluation/therapy

_____Full participation in evaluation/therapy

_____Rehabilitation evaluations completed with in 2 days

Identify the new medical condition that decreases the client's participation in therapy for less than 3 hours/day for up to 3 days. _____

What medical/psychosocial management is required for this client? _____

_____

Exhibit 12 (continued)

Client's Name: _____

Program Coordination

What is the ongoing needs assessment/procurement? _____

What instruction does the client require? _____

What is identified as discharge needs, barriers, client support systems? _____

Disposition Planned:

1. If Goals Achieved: _____
2. If Goals Not Achieved: _____

Physiatrist's Plan of Care and Recommendation (if applicable):

Exhibit 13

Physical Rehabilitation Review Worksheet for Concurrent Review

Call Date: _____ Caller: _____ Reference # _____

Admit Date: _____

Client's Name: _____

Medicaid #: _____

Rehabilitation Facility: _____

Phone #: _____

New Procedures: _____ Date: _____

In general, has measurable improvement been documented weekly? Yes ☐ No ☐

Indicate: 1. Specific improvement in the following areas or lack of, and

_____

_____

2. Revision of goals if necessary

_____

_____

Improvements:		**Comments:**
Cognitive Function	Y ☐ N ☐	_____
Communication	Y ☐ N ☐	_____
Continence, Bowels	Y ☐ N ☐	_____
Continence, Bladder	Y ☐ N ☐	_____
Mobility	Y ☐ N ☐	_____
Pain Management	Y ☐ N ☐	_____
Perceptual Motor Function	Y ☐ N ☐	_____
Self–Care Activities	Y ☐ N ☐	_____

Exhibit 13 (continued)

Client's Name: _____

Intensity of Service

Will The Progressive Therapy Program consist of at least 2 disciplines and 3 hours/day or greater and 5 days/week for:

_____ ADLs
_____ Bed mobility/Transfers
_____ Home Lifestyle modifications
_____ Positioning/Splinting
_____ Pulmonary rehabilitation
_____ ROM/Strengthening
_____ Speech language retraining
_____ Swallowing retraining
_____ Wheelchair mobility/Ambulation/Balance

If this is an admission trial of 1 week or less, the program will provide:

_____At least 2 disciplines and 3 hours/day or greater and 5 days/week or greater of evaluation/therapy

_____Full participation in evaluation/therapy

_____Rehab evaluations completed with in 2 days

Identify the new medical condition that decreases the client's participation in therapy for less than 3 hours/day for up to 3 days. _____

What medical/psychosocial management is required for this client? _____

_____

Program Coordination

What is the ongoing needs assessment/procurement? _____

_____

What instruction does the client require? _____

_____

What is identified as discharge needs, barriers, client support systems, and client capabilities? _____

_____

_____

_____

_____

Exhibit 13 (continued)

Client's Name: _____

Disposition Planned:

1. If Goals Achieved: _____
2. If Goals Not Achieved: _____

Physiatrist's Plan of Care and Recommendation (if applicable):

_____

_____

_____

_____

_____

_____

_____

Number of Days Requested: _____

Number of Days Approved: _____

Approved Until: _____

Authorization #: _____

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Section XII. Out of State (Non–Bordering County) Review

Effective January 1, 2000, all medical care outside the State of Idaho is subject to the same utilization review and coverage requirements and restrictions as medical care received within the State of Idaho.

For questions regarding medical transportation to any location contact:

Idaho Medicaid Transportation
Non-Emergency Authorization
Phone: 1-800-296-0509
(208) 334-4990
FAX: 1-800-296-0513

Ambulance Authorization
Phone: 1-800-362-7648
(208) 287-1157
FAX: 1-800-359-2236

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Section XIII: Quality of Care Reviews

A. Purpose

Qualis Health is committed to promoting optimum quality of care for all clients and, therefore, will assess quality of care in various settings while performing reviews.

B. Responsibility

The facility and attending physician are responsible to deliver the utmost quality of care for their patients. Qualis Health is responsible for identifying potential quality of care concerns regarding clients of the Department of Health and Welfare. Potential quality of care issues may be identified by a Qualis Health Nurse Reviewer, Medical Director, or Physician/Practitioner Consultant (P/PC).

C. Requirements

Potential quality of care concerns may be identified during all types of reviews including retrospective chart reviews.

D. Procedure

If a Qualis Health nurse reviewer identifies a potential quality of care concern when performing a telephonic review, the situation will be handled in the following way:

If the Qualis Health nurse reviewer identifies that the client's quality of care is *currently* being compromised, s/he will consult a Qualis Health physician/practitioner consultant. If the physician/practitioner consultant concurs that there is a potential quality of care concern, the case will be referred to the Qualis Health Medical Director for discussions with the Department.

If a potential quality of care concern is identified during a retrospective chart review, Qualis Health will refer the case to the Department for further action.

Quality of care reviews will be conducted by Qualis Health only at the request of the Department.

With approval of the Department, Qualis Health's Medical Affairs Department will conduct a quality of care review and determine appropriate action. The review will address the general case type and the seriousness of the case. For example:

- The case type classification would look at whether the care involved elements of procedural, proficiency, communication, or protocol errors.
- Case severity would be evaluated using concepts related to standard care, variation of care, care done in the best interest of the patient, and care outside standard of care.

The Qualis Health medical director will also determine and recommend to the Department the appropriate oversight body for referral for investigation of the quality of care issue or incident in question. Organizations with responsibility for oversight of quality of care for patients include:

- State licensing and quality boards for physicians and other providers
- State licensing and quality boards for hospitals, nursing homes, skilled nursing facilities, adult homes, etc.
- Hospital and facility quality oversight councils or committees
- Credentialing organizations
- Third party payors, managed care companies, provider networks, medical group practices, etc.

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Section XIV: Retrospective Review — Retroactive Eligibility

A. Purpose

Retrospective review in any form is not the most advantageous review for either the review organization or the provider. A review of a facility confinement that is conducted after the client has entered or has been discharged can lead to contested non–certification of days.

However, retrospective reviews are necessary for Medicaid and FACS clients when eligibility is established retroactively.

B. Responsibility

The facility utilization review nurse is responsible to review each chart for the appropriate information required prior to calling the Seattle office of Qualis Health for any retrospective review of inpatient stays *less* than 15 days.

For a hospital stay 15 days and greater or an IMD review, the facility is responsible to submit a complete legible copy of the entire medical record to Qualis Health.

C. Requirements

Retroactive eligibility review is required only for those outpatients or inpatient hospitalizations where the primary diagnosis or procedure would have required pre–service review or the hospitalization exceeded three days.

Retroactive eligibility review applies to those clients who were not Medicaid eligible at the time of admission and Medicaid eligibility was established at a later date.

For DHW clients who make application for Medicaid during an inpatient stay and subsequently become Medicaid eligible prior to discharge, providers are required to notify Qualis Health by telephone as soon as it is known the client is Medicaid eligible and a review is required. Qualis Health will proceed with performing certification review if the client is in the facility when eligibility is established. Days prior to eligibility being established will be reviewed retrospectively via telephone if the length of stay is less than 15 days or will be reviewed via chart if the length of stay is 15 days and greater.

If the length of stay is 15 days and greater or is an IMD review (client is under the age of 21 with a psychiatric diagnosis), a complete legible copy of the entire medical record is to be mailed to Qualis Health's Seattle office for review.

For Medicaid clients with retroactive eligibility who have had an outpatient procedure or have been discharged, the facility must request a retrospective review. A *Retrospective Review Request Form* (refer to Exhibit 14) must be completed and submitted with a copy of the *UB–92*, history and physical, discharge summary and operative report, if applicable, for stays less than 15 days. Allow five (5) business days for processing before calling Qualis Health to complete the telephonic review. For stays 15 days and greater, the *Retrospective Review Request Form* must be completed and submitted with a copy of the UB–92, and a complete legible copy of the entire medial record.

Note: Effective April 2005, neonate reviews will require submission of the last two weeks of the medical record in addition to other documents listed on the Retrospective Review Request Form. If additional information is required, you will be contacted.

Submit Retrospective Review Request Form to:

Qualis Health
Attn.: Care Management Department/Retrospective Review
P.O. Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133

If EDS has denied claims for physician services because a prior authorization has not been obtained, the physician's office personnel should contact the facility utilization review department to inquire whether a retrospective review has been requested. All requests should be initiated by the facility.

There will be no reimbursement for photocopying or postage expense for the portions of the medical record sent with the retrospective request.

After reviewing the Retrospective Review Form sent by the facility, Qualis Health may make one of the following determinations and notify the facility by phone and/or fax:

1. Qualis Health may have previously reviewed and certified the procedure or diagnosis. No additional review is necessary. The facility should insert the Case ID number given by Qualis Health on the claim form and send it to EDS for processing.
2. Qualis Health may non–certify the review because the client was not eligible at the time of service and/or the services were not billed within the one–year claim submission limitation.
3. Qualis Health may determine that the client had Medicare as their primary coverage at the time of service. Follow Medicare guidelines for review. Claims submitted to Medicare will "cross–over" to Medicaid for processing and will not require additional QIO review.
4. Qualis Health may determine that the service is not a covered benefit or does not require review by Qualis Health. Some procedures may require review by the Department's Care Management Unit. Fax requests for these reviews to 208-364-1864.

   For inquiries of these determinations, contact:
   Division of Medicaid, Arlee Coppinger at 208-287-1177

D. Time Frames for Retrospective Eligibility Review Decisions

With all necessary clinical information received and no referral for clinical peer review, the timeframes are:

Review Type	Timeframes for Completion from Date of Notification to Qualis Health
Retrospective Review	Thirty calendar days

When additional information is required to complete the review, the timeline is adjusted accordingly.

Qualis Health may choose to exercise a single extension of up to 15 calendar days on non–urgent reviews when there are reasons beyond the control of the organization that requires an extension. When this occurs, Qualis Health must inform the provider (by the date on which notice of the initial decision would normally be due) of the circumstances that require the extension and the date by which it expects to reach a decision. This single extension is only allowed on non–urgent reviews, since it is not allowed for urgent care reviews.

E. Procedure

1. Retroactive Eligibility Review Less Than 15 days

   For all outpatient procedures requiring review and facility confinements of less than 15 days, with the exception of IMD reviews, a copy of the ***UB–92, History and Physical, Discharge Summary,*** and ***Operative Report,*** if applicable, must be mailed to Qualis Health's **Seattle** office with the completed *Retrospective Review Request Form*.

Qualis Health
Attn.: Care Management Department/Retrospective Review
P.O. Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133

Providers may either submit clinical information with the faxed retrospective review request form or providers may call to provide the clinical information five days after submitting the retrospective review request form to Qualis Health.

The Qualis Health nurse reviewer will review the information provided and apply *InterQual® Criteria for Non–physician Review*. If the InterQual® criteria are met, the Qualis Health nurse reviewer will issue a Case ID number. Qualis Health nurse reviewers will follow the Qualis Health policy regarding referral to physician review. **EDS Corporation, the fiscal agent for the Department, will be notified by electronic data transfer.**

If the client is still in the facility at the time of the initial retroactive eligibility review, the review will be conducted according to concurrent review format.

Qualis Health certification indicates only that the admission is medically necessary. This certification does not guarantee payment for services rendered. Payment is contingent upon eligibility and compliance with the rules and regulations that govern Medical Assistance in Idaho.

2. Retroactive Eligibility Review 15 Days and Greater

   For retroactive eligibility reviews where the length of stay is 15 days and greater and all IMD reviews, a complete legible copy of the entire medical record must be mailed to Qualis Health's Seattle office with the completed Retrospective Review Request Form and a copy of the UB–92.

Qualis Health
Attn.: Care Management Department/Retrospective Review
P.O. Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133

The Qualis Health nurse reviewer will review the information provided and apply *InterQual® Criteria for Non–physician Review*. In addition to the review for medical necessity and appropriate utilization, the nurse reviewer will also screen the medical record for potential quality of care concerns. Refer to Section XIII regarding quality of care concerns.

If the screening criteria are met, a Qualis Health nurse reviewer will issue a Case ID number and the facility QIO contact person or appropriate parties will be notified. Qualis Health nurse reviewers will follow the Qualis Health policy regarding referral to physician review. These reviews will be completed within 30 days from the date Qualis Health receives the entire chart. EDS Corporation, the fiscal agent for the Department, will be notified by electronic data transfer.

Providers will be reimbursed by Qualis Health for medical record photocopying charges at the current national rate determined by the Center for Medicare and Medicaid Services (CMS) of $0.07 per page. This rate will remain in effect until which time any changes become federally mandated. Postage will be reimbursed at the rate of first class mail. (See Exhibit 15, Photocopying Invoice.)).

3. Retrospective Review: Chart Requests

   Occasionally when performing reviews by telephone, a Qualis Health nurse reviewer or physician/practitioner consultant may request the chart of a client to verify quality of care or accuracy of the information provided. The Qualis Health nurse reviewer will request the client's chart either telephonically or in writing. The review determination rendered as a result of a chart review will always take precedence over a telephonic review determination.

F. Non–certifications

If the screening criteria are not met, a Qualis Health nurse reviewer will refer the review to a Qualis Health physician/practitioner consultant.

If the Qualis Health physician/practitioner consultant non–certifies the admission or a portion of the hospitalization, Qualis Health will send non–certification notifications within one working day to the following parties: the attending physician, the facility, the Department, and the client. The non–certification notifications will contain an explanation of the right to request an appeal of Qualis Health's determination. **EDS Corporation, the Department's fiscal agent, will be notified by electronic data transfer.**

NOTE: Telephonic Retrospective Reviews:

There are time constraints involved for potential non–certifications. The Qualis Health intake representative or nurse reviewer will notify the facility utilization review coordinator of the potential non–certification and request that the utilization review coordinator contact the attending physician to offer the option of a peer–to–peer discussion.

If a peer–to–peer conversation is desired by the attending physician, it is necessary to call Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time the day following notification of the potential non–certification. If the attending physician is not able to call within the stated time frame and an extension is desired, please notify Qualis Health by 6:00 PM Mountain Time / 5:00 PM Pacific Time of the next business day.

If the case is non–certified after the peer–to–peer conversation, the stay will be non–certified retroactively to the day medical necessity was not met. If the **attending physician** does not call by 6:00 PM Mountain Time / 5:00 PM Pacific Time the following day, the case will be non–certified. The attending physician may use the physician "hotline," 1-877-292-2615, to discuss the client's case.

Retrospective Chart Reviews

Since a copy of the medical record is reviewed for a chart review, a peer–to–peer conversation is not offered. It is felt that all pertinent information regarding the admission is recorded in the medical record.

G. Appeals

Refer to Section XX of this manual for a detailed description of the appeal procedure.

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Exhibit 14

Retrospective Review Request Form

PATIENT INFORMATION		Request Date:
Patient Name	Patient Date of Birth	Insurance ID #

Insurance Information: ☐ AK Medicaid ☐ ID Medicaid ☐ WA Labor & Industries ☐ Private

FACILITY INFORMATION			
Facility	Admit Date	Discharge Date	Physician
UR Contact Person	UR Phone #	Fax #	

Request Reason (PLEASE CHECK ALL THAT APPLY):

☐ Exceeds LOS ☐ Pre–Service Review Late ☐ Other _____

☐ Medicaid Patient (Eligible post admit date) eligible date _____

☐ Medicaid Eligible (Eligible before admit date) eligible date _____

☐ Concurrent Review Late Previous authorization # _____

For lengths of stay **less than 15 days, please submit the following information:**

☐ UB 92 ☐ DC Summary

☐ H & P ☐ Operative Report (if applicable)

For lengths of stay **15 days or greater** & ID Medicaid psych diagnosis for patients under age 21,
PLEASE SEND ENTIRE MEDICAL RECORD

Additional Information needed for

- Rehabilitation: Weekly Team Meeting Notes, Functional Status, Goals
- Adult Psychiatric/Chemical Dependency: MD and Multi–disciplinary Progress Notes, Medication Administration Record

ADDITIONAL INFORMATION MAY BE REQUESTED

Fax completed form to Qualis Health
AK Medicaid Patients: 800-826-3630
ID Medicaid Patients: 800-826-3836
WA Labor & Industries Patients: 877-665-0383
Private Patients: 877-810-9265

Mail medical record to Qualis Health
Qualis Health
PO Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133-0400

For Internal Use Only – Calls Made for Additional Information

☐ _____ ☐ _____ ☐ _____
date date date

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Exhibit 15

Photocopying Invoice
Idaho Medicaid

Qualis Health will reimburse the facility for photocopying charges and postage at the rate of regular mail for requested medical records sent to Qualis Health for chart review of admissions of Idaho Medicaid and FACS clients. Charges for copies of medical records sent to the **Department** with the *Retrospective Review Request Form* will **not** be reimbursed. Please use this form as your invoice by providing the following information:

Facility_____ Client Name_____

Address_____ Medicaid #_____

_____ Date Submitted_____

Total # Pages Copied: _____ x $0.07 = _____ Total Photocopying

_____ Total Postage

_____

_____ TOTAL INVOICE

Invoice Prepared by _____ (Contact Person)

Telephone Number _____

Invoice Verified By_____ (Qualis Health)

Date Submitted to Qualis Health Accounting and Finance Department _____

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Section XV: Retrospective Review ("Late" Review)

A. Purpose

Qualis Health will perform reviews retrospectively when the client was Medicaid eligible at the time of the facility admission but the provider failed to obtain the appropriate certification in a timely manner, and the client has been discharged from the hospital.

B. Responsibility

The facility utilization review department is responsible to request these reviews from Qualis Health utilizing the Qualis Health *Retrospective Review Request Form* (see Section XIV, Exhibit 14).

C. Requirements

The facility is responsible for providing Qualis Health with a **complete legible copy of the entire medical record** for those reviews in which the length of stay is 15 days and greater. Late Reviews of facility stays less than 15 days will be conducted telephonically.

D. Procedure

The same review procedure described in Section XIV, Part E, *Procedure for Retroactive Eligibility Reviews*, will be followed for Retrospective Late Reviews.

E. Penalties

Late reviews will be reported to Idaho Medicaid and will be subject to a penalty after claims are paid. Hospital penalties are assessed at $260.00 per late day, with a maximum of five (5) days ($1300.00). Physician penalties are assessed at $50.00 per late day, with a maximum of five (5) days ($250.00). Physicians will only be subject to penalty for failure to request a timely review of services requiring preauthorization–service review.

Penalty notification letters will be sent on a quarterly basis by the Department. Appeals of penalty assessment should be directed to the Division of Medicaid, Financial Operations at **208-287-1152 or FAX to 208-334-6515 or toll free : 1-866-852-2954.**

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Section XVI: Focused Case Reviews

A. Purpose

Focused case reviews for Medicaid and FACS clients may be reviewed at any time at the direction of the Department.

Focused case reviews may include utilization review of all inpatient medical services for a specific client received over a specific time period to assure continuity and quality of care.

B. Responsibility

The Department will select cases for focused case reviews at any time on a case–by–case or provider–specific basis.

Facilities will be notified in writing of those records selected for focused case reviews.

A complete legible copy of the entire medical record and additional information requested is to be mailed by the facility to Qualis Health's Seattle office at the following address:

Qualis Health
Attn.: Care Management Department/ Focused Case Review
P.O. Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133

Providers will be reimbursed for photocopying charges at the current national rate of $0.07 per page as determined by the Center for Medicare and Medicaid Services (CMS). This rate will remain in effect until such time any changes become federally mandated. Postage will be reimbursed at the rate for first class mail.

C. Requirements

The facility is to submit a complete legible copy of entire medical record to Qualis Health within 30 days of receipt of notification of cases selected for review.

D. Procedure for Focused Case Reviews

Qualis Health will report the result of the review to the Department only. Notification to other parties will be at the direction of the Department.

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Section XVII. Procedure for Weekends and Holidays

In those instances where the concurrent review date falls on a weekend or holiday, the review will be due the following business day. If the provider notifies Qualis Health on the following business day, the review will not be considered a late review.

Non–certification may be retrospective to the first day the client did not meet criteria.

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Section XVIII: Leave of Absence

It is the policy of the Department that when a client is not present in the facility at the time of the facility census (e.g., 12:00 00 midnight), the client is considered discharged. **Neither the facility nor the physician will be reimbursed for the days the client is/was not present in the facility.**

To accurately reflect the non–covered facility day(s), a new review must be initiated by Qualis Health each time a client returns to the facility. This will result in issuance of a new review and Case ID number by Qualis Health, if certified. Consequently, the finance department of each facility will need to submit a separate billing to the Department's fiscal agent, EDS Corporation, to coincide with each Qualis Health Case ID number and the respective admission and discharge dates.

This policy also applies to any leave of absence situations identified by Qualis Health nurse reviewers performing chart reviews (retrospective reviews).

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Section XIX: Administratively Necessary Days ("ANDs")

Administrative necessary days (ANDs) are intended to allow hospital time for the disposition of a client who no longer requires an acute level of care, but alternative care is required to secure the safety of the client. If *non–certification* of a concurrent review has been determined by Qualis Health, the facility may request up to three (3) AN days. The Department may approve additional ANDs if the transfer of a patient to a lower level of care cannot occur due to circumstances beyond the control of the hospital and the Department.

The hospital discharge planner, utilization reviewer, or attending physician must contact the Department of Health & Welfare's Medicaid Bureau of Care Management by phone or fax to request AN Days. The AN Days Intake Form must be submitted **prior** to acute hospital discharge and can be done as soon as the discharge planner anticipates a possible discharge issue, even before the final non–certified date is known. The facility must then supply the additional required documentation within ten (10) working days of the submitted request. If the AN Days are not necessary, due to a reversal of the possible non–certification, please notify the Care Management Unit and the request will be voided.

To request AN Days, please fax request form and required documentation to:

Department of Health and Welfare
Division of Medicaid
Attention: Care Management

Phone: 208- 364-1904 Monday – Friday, 8 a.m. – 5 p.m. MST
Phone: 208-364-1904 Fax: 208- 332-7280

The following documentation will be needed for authorization of an AN Day:

- AN Days Intake Form (see attached form)
- Summary of client's medical condition
- Current history and physical
- Physician progress notes
- Statement as to why client can not receive necessary medical services in a non–hospital setting
- Documentation that the hospital has diligently made every effort to locate a facility or organization to deliver appropriate services

Services to an individual who received retroactive eligibility will be deemed prior approved if the individual was not eligible for Medicaid at the time the service was provided, but was subsequently found eligible. The Department approves the service provided by the same guidance that applies to other authorization requests for AN Days.

The Department will review requests and FAX the authorization number to the provider for approved ANDs. A Notice of Decision letter for each request, approved or denied, will also be mailed to the provider.

Limitations:

Each client is limited to no more than three AN Days per admission. There is no limit to the number of AN Days allowed per year.

Refer to IDAPA 16.03.09.162 and the Idaho Medicaid Provider Handbook under Administratively Necessary Days, in the Hospital Service Guidelines Section for additional information regarding limitations and requirements.

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Exhibit 16

ADMINISTRATIVE NECESSARY DAYS (AND) INTAKE FORM

FAX TO: Idaho Medicaid Care Management
(208) 332-7280

Today's Date	
Requesting Agency Name	
Contact Person	
Phone #	
Fax #	
Address	
Hospital Medicaid Provider #	
Attending Physician	
Hospital admission date	
Patient Name	
Medicaid #	
Diagnosis	
ICD–9 Codes	
Reason for AND Request	
AND Dates requested	
Supporting Documents Required – please attach the following	Summary of patient's medical condition Current History and Physical Physician progress notes Statement as to why patient can not receive necessary medical services in a non–hospital setting Documentation that the hospital has diligently made every effort to locate a facility or organization to deliver appropriate services
MEDICAID USE ONLY	
# of AND days Approved	
Dates Approved	
Authorization #	
Request Denied	
Reason Denied	
Log Completed by Staff Signature	

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SECTION XX: Appeal Procedure

A. Expedited Appeal

Qualis Health has a procedure in place for addressing expedited appeal requests for Idaho Medicaid clients and providers. Expedited appeals will be performed in Qualis Health's Seattle office in **Care Management** for the following review programs:

- Pre–service Review
- Concurrent Review

In all cases, the care in question must meet the definition of urgent care (See pages 8, 17 and 128 of this provider manual).

Please direct requests for expedited appeals to:

Qualis Health
Attn: Care Management Department/Appeal Review
P.O. Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133
Phone: (800) 783-9207
FAX: (800) 826-3836

For appeal reviews, the Qualis Health physician/practitioner consultant will be board–certified in the same or similar specialty as the attending physician who normally cares for the patient's condition.

Procedures:

a) The client, attending physician or facility may request an expedited appeal of the initial non–certification by FAX, telephone, or in writing within two business days of receipt of the non–certification notification if the client has not been discharged.

b) If an expedited appeal request is filed after two business days, Qualis Health will respond to that request through the standard appeal process. (See Section XX, Part B).

c) Upon receipt of a FAX, telephonic, or written request for an expedited appeal, the Qualis Health nurse reviewer will notify all appropriate parties of the request.

d) The Qualis Health nurse reviewer may request additional medical information (i.e., medical records and/or physician office notes) be submitted to Qualis Health within two hours.

e) The Qualis Health nurse reviewer will refer the review to a Qualis Health physician/practitioner consultant who is licensed and/or accredited in the appropriate specialty or subspecialty, but this physician will not be the same individual who initially reviewed and non–certified the review.

f) The Qualis Health physician/practitioner consultant will review the medical information.

   If the physician/practitioner consultant reverses the non–certification decision, the nurse reviewer will issue a Case ID number and length of stay (if applicable) and will notify all appropriate parties telephonically and in writing.

   The Qualis Health physician/practitioner consultant may modify the decision or uphold the non–certification. The requesting physician or facility will be notified telephonically.

g) The Department's MMIS/AIM will be updated accordingly.

h) Notification with the review outcome, including clinical rationale will be sent to the client, attending physician and facility. The Department's MMIS/AIM will be updated accordingly.

i) If the client, attending physician, or facility disagrees with the expedited outcome, the standard appeal process may be followed.

B. Standard Appeal

Non–certification notices inform the attending physician, facility, and client of the right to seek an appeal of the initial non–certification or expedited appeal determination by Qualis Health. The notice explains that the right to appeal exists even after the client leaves the health care facility. This request for appeal must be submitted in writing, by telephone or by FAX to Qualis Health within 180 days of the date shown on the non–certification notice.

Note: Effective April 2005, appeal requests for "neonate reviews" will require submission of the last two weeks of the medical record as opposed to the complete medical record, unless otherwise requested.

Providers will have 15 days from the date of the appeal request to submit additional clinical information for consideration by Qualis Health.

Please direct the request for standard appeal to:

Qualis Health
Attn: Care Management Department/Appeal Review
P.O. Box 33400
10700 Meridian Avenue North, Suite 100
Seattle, WA 98133
FAX: 1-800-826-3836
or
Phone: 1-800-783-9207 and request an appeal.

Any request for appeal of a non–certification will be reviewed by a Qualis Health physician/practitioner consultant licensed and/or accredited in the appropriate specialty or subspecialty as the attending physician but will not be the same individual(s) who initially non–certified the review.

Qualis Health will issue the appeal decision **within 30 days of receipt of the request for a standard appeal.** All appropriate parties will be notified in writing of Qualis Health's determination to uphold, reverse, or modify the initial non–certification decision.

Qualis Health's appeal decision will take precedence over the initial non–certification decision. For example, if the appeal review certifies more facility days than the original review, then more facility days will be recommended for certification. Conversely, if the appeal review certifies fewer days than the original review, then fewer facility days will be recommended for certification. Refer to Exhibit 18, *Standard Appeal Process* Flow Chart.

C. Department Appeal

The Department appeal procedure is the process by which a physician, facility providers, and/or Medicaid clients can contest the Qualis Health appeal determination. The Department appeal procedure can be initiated only after the Qualis Health appeal procedure has been exhausted and within the specified time limits.

All requests for appeals from providers (contested case hearing) must be submitted in writing to the **Department** within 28 days of the date on Qualis Health's appeal decision letter. All requests

for appeals from clients (fair hearing) must be submitted in writing to the Department within 28 days of the date on Qualis Health's appeal decision letter. The request must state the rationale for the appeal.

Each provider who decides to contest the non–certification of payment by the Department must request an appeal hearing on his own behalf. The post–hearing decision will affect reimbursement only to those providers who requested the hearing. Denial of payment will be upheld for all other affected providers.

The address to send requests for a **contested case hearing** is:

Hearings Coordinator
Department of Health and Welfare
Administrative Procedures Section
Pete T. Cenarrusa Building, 10th Floor
P. O. Box 83720
Boise, ID 83720–0036
Phone (208) 334-5564
FAX: (208) 334-6558

You will be contacted in writing by a hearing officer, who will arrange the administrative hearing at a time and location convenient for you.

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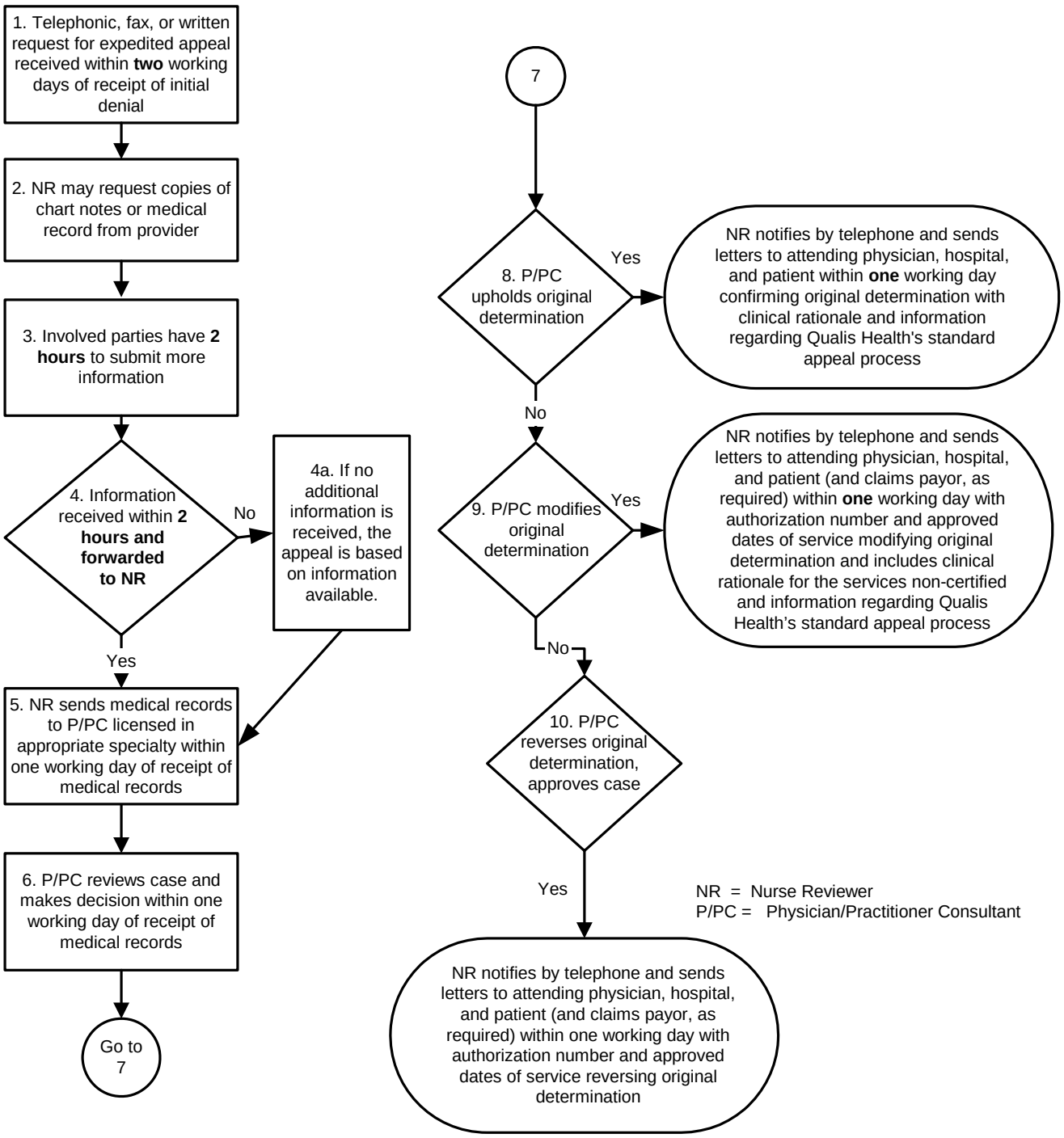
Expedited Appeal Process

Exhibit 17



Definition of Expedited Appeal: An appeal of a non–certification in a case involving urgent care.

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Standard Appeal Process

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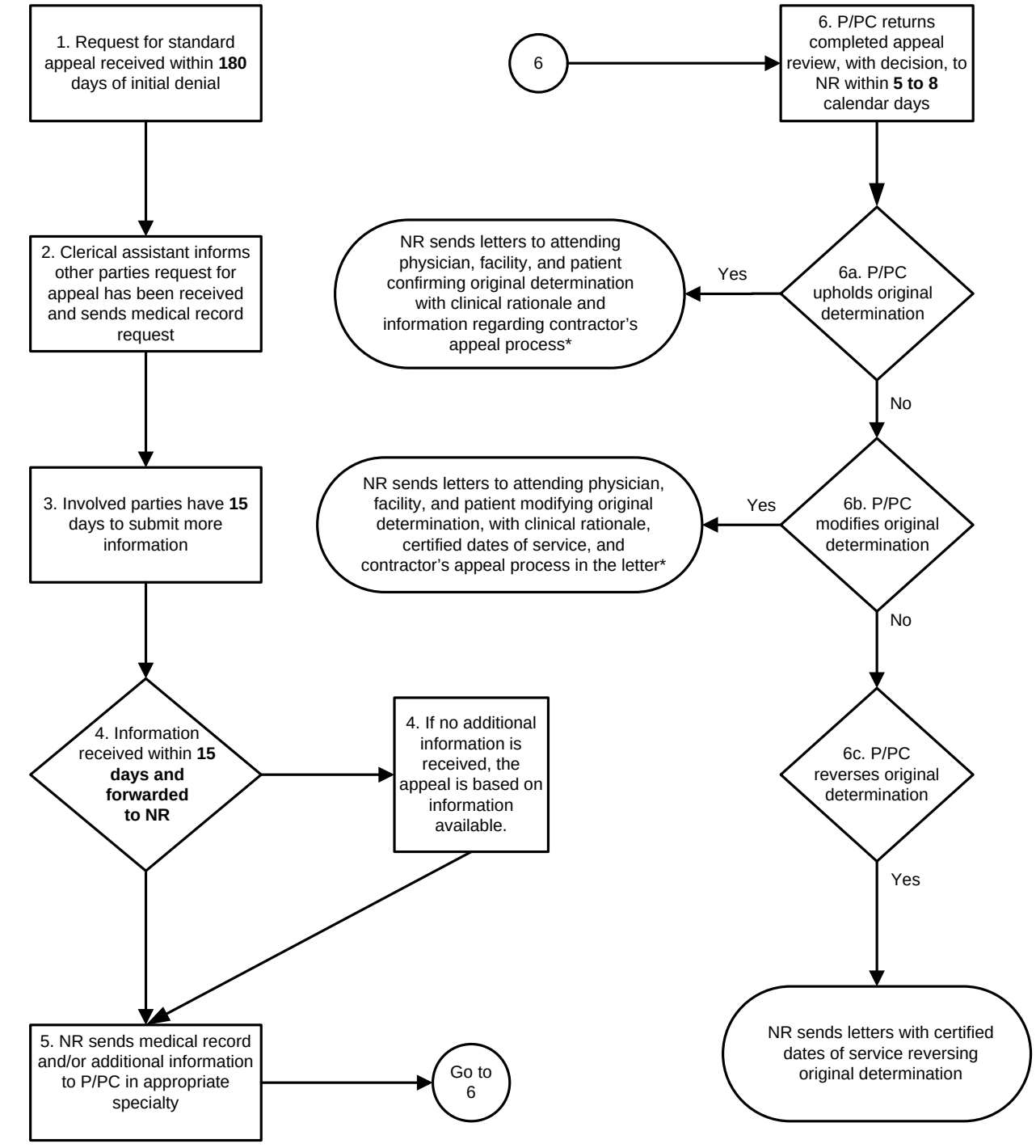
Exhibit 18



*Review completed and letters mailed within **28** days of receipt of request to perform standard appeal

NR = Nurse Reviewer
P/PC = Physician/Practitioner Consultant

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Section XXI: Case Management

A. Definition

Case Management (CM): A collaborative process of assessment, planning, facilitating, and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality, cost–effective outcomes
(Source: Case Management Society of America, Standards of Practice 2002)

B. Purpose

1. Identify and engage clients in appropriate care.
2. Monitor cost effective use of all resources.
3. Develop coordinated collaborative plans with all providers involved on an individual basis.
4. Enhance quality improvement by monitoring and facilitating appropriateness of care.
5. Facilitate timely discharges and transfers based on individuals' needs and level of care requirement.
6. Serve as a resource to clients, providers, and Idaho Medicaid.

C. Special Requirements

Case management services are provided from the Seattle office.

1. Case management is considered a voluntary program for clients. All clients will be asked to sign a release of information indicating their willingness to participate in the case management process.
2. Idaho Medicaid clients are eligible for case management services regardless of location.
3. Clients who are on the Idaho Medicaid Waiver Programs can receive case management with the approval of Idaho Medicaid.
4. Case management services are, for the most part, provided telephonically.

D. Targeted Cases

1. High cost cases targeted by Utilization Review
2. Screening will be performed for the following diagnoses:

Admissions with length of stay greater than 5 days
Burns/Wounds/Non–healing Ulcers
Cancer
Cardiovascular Disease
Chronic Respiratory Disease
Complicated Pregnancy
Congenital Defects
Congenital Heart Disease
High Risk Pregnancy
HIV/AIDS
Mental Health Conditions
Multiple Medical Conditions
Neonatal Complications
Neurodegenerative Disorders (ALS, MS, MD)
Neurological Conditions (Aneurysm, Meningitis, Encephalitis, etc.)
Organ and bone marrow/stem cell transplants
Possibility of Severe Permanent Impairments
Rehabilitation
Re–hospitalizations and Multiple Treatments that have occurred or are planned
Spinal Cord Injuries
Traumatic Brain Injury
Traumatic Injuries (Multiple Trauma, Amputation, etc.)

E. Case Identification Process

1. Cases may be identified and referred from multiple sources, including EDS, Idaho Medicaid, providers and the operations department for Care Management in the Seattle office.
2. Currently, Qualis Health Utilization Review has a very efficient screening process in place and preliminary case management identification begins at that level. Cases are screened by the lead case manager and involved parties and facilities are then notified of case management intervention.

a. Procedure for Opening Cases

1. Once a case has been screened and found to meet case management criteria, it will be reviewed with Idaho Medicaid for approval of on going case management services.
2. A case manager will begin the initial case management process, which includes:
   - Gather information to help identify the best health care for the client
   - Make recommendations regarding the client's health care needs
   - Inform health care team members about benefits and available resources
   - Coordinate referrals and assist in obtaining appropriate health care services

3. A complete report listing case management interventions, goals, and recommendations is submitted to Idaho Medicaid on a regular basis.

b. Procedure for Provider Interface

1. The case manager will make contact with all ancillary care providers involved with the client's care.
2. The case manager will work collaboratively with all health care providers to assure all services are appropriate and medically necessary.

c. Procedure for Closing Cases

1. Once it is determined that case management services are no longer indicated, i.e., patient's medical condition stable and all appropriate services in place, no ongoing needs, the case will be reviewed with Idaho Medicaid regarding closure.
2. The client will be notified by phone or correspondence that the case is being closed.
3. Satisfaction Questionnaires are regularly sent to client or family at the time of case closure.

F. Integrated Utilization Management (UM) and Case Management (CM) Program

Qualis Health provides integrated UM/CM services for the following complex cases/selected populations:

- Inpatient rehabilitation cases
- Neonatal cases
- Complicated pregnancy cases

For those clients in the above populations who are in case management, Qualis Health's case managers also perform the utilization review services. The case manager then becomes the single point of contact and monitors both utilization management and case management services for the patient. Using a case manager for reviews provides a more comprehensive approach to coordination of services for complex cases and helps to ensure appropriate utilization of services. Through the integration of UM/CM services outcomes are optimized including increased provider satisfaction and increases in days saved per admission.

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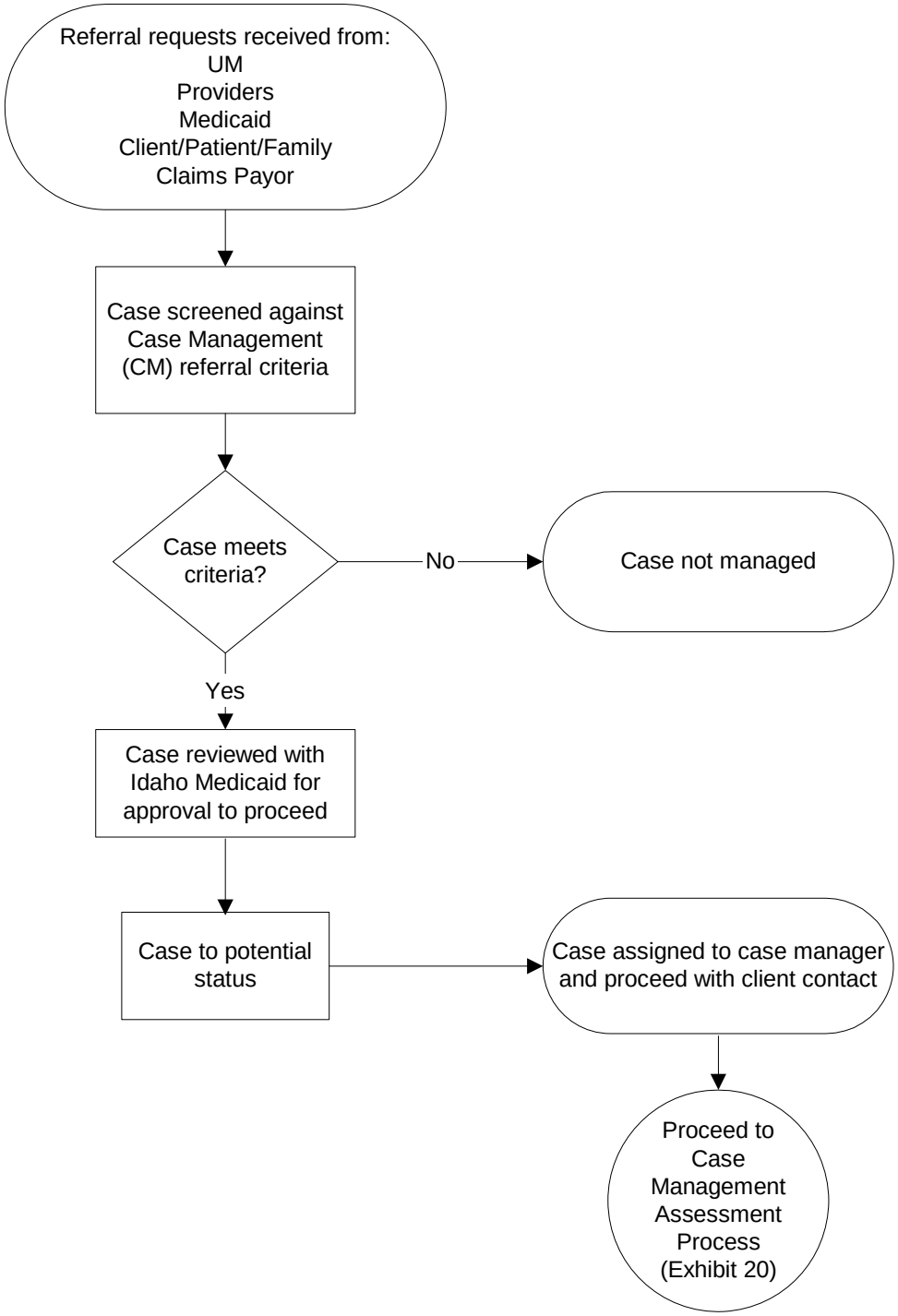
Case Management Referral Process

Exhibit 19



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Case Management Assessment Process

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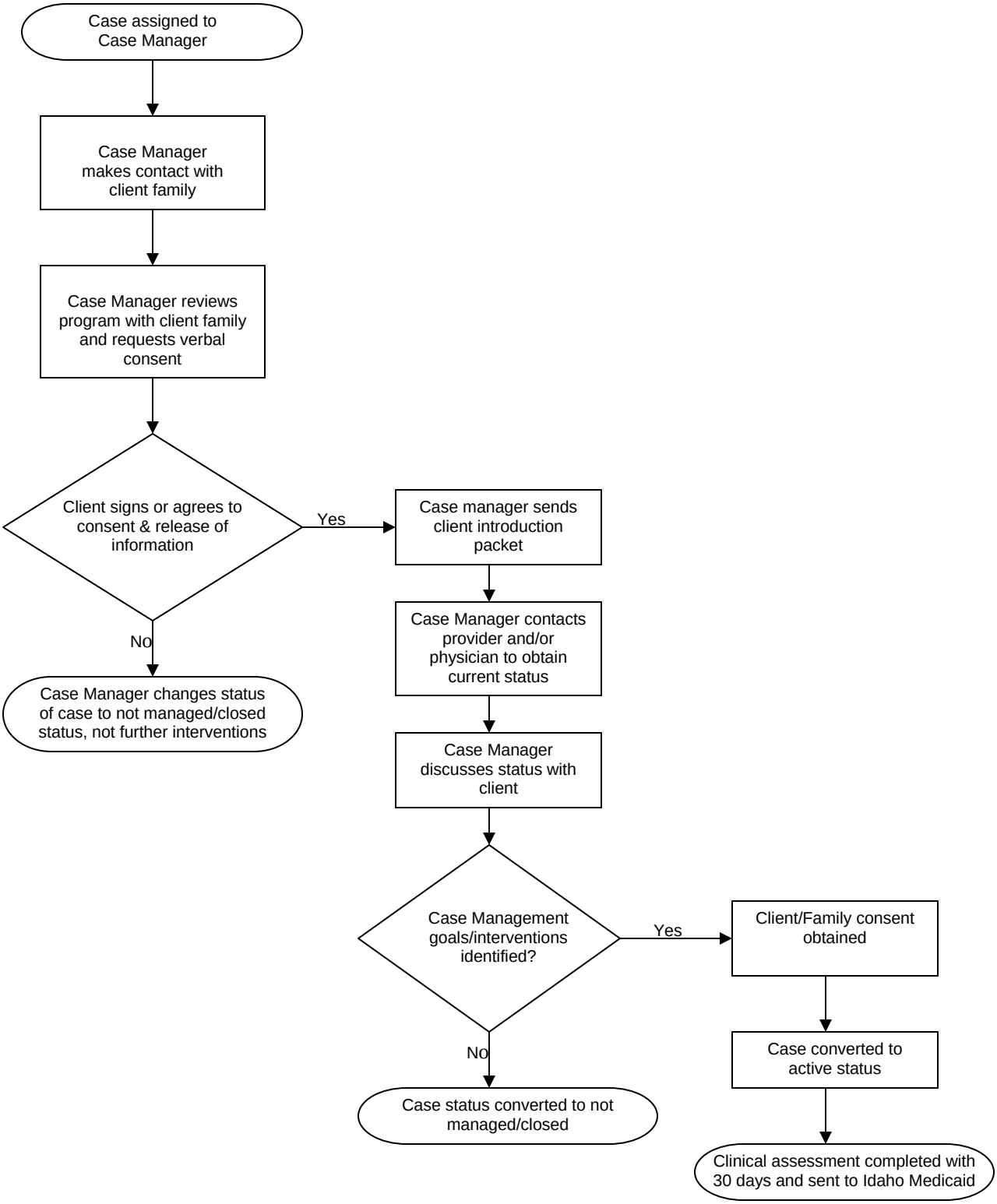
Exhibit 20



*Introduction packet includes Release of Information, Patient Introduction, Overview of Services, and Patient Bill of Rights

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Case Management Workflow Initial Assessment to Closure

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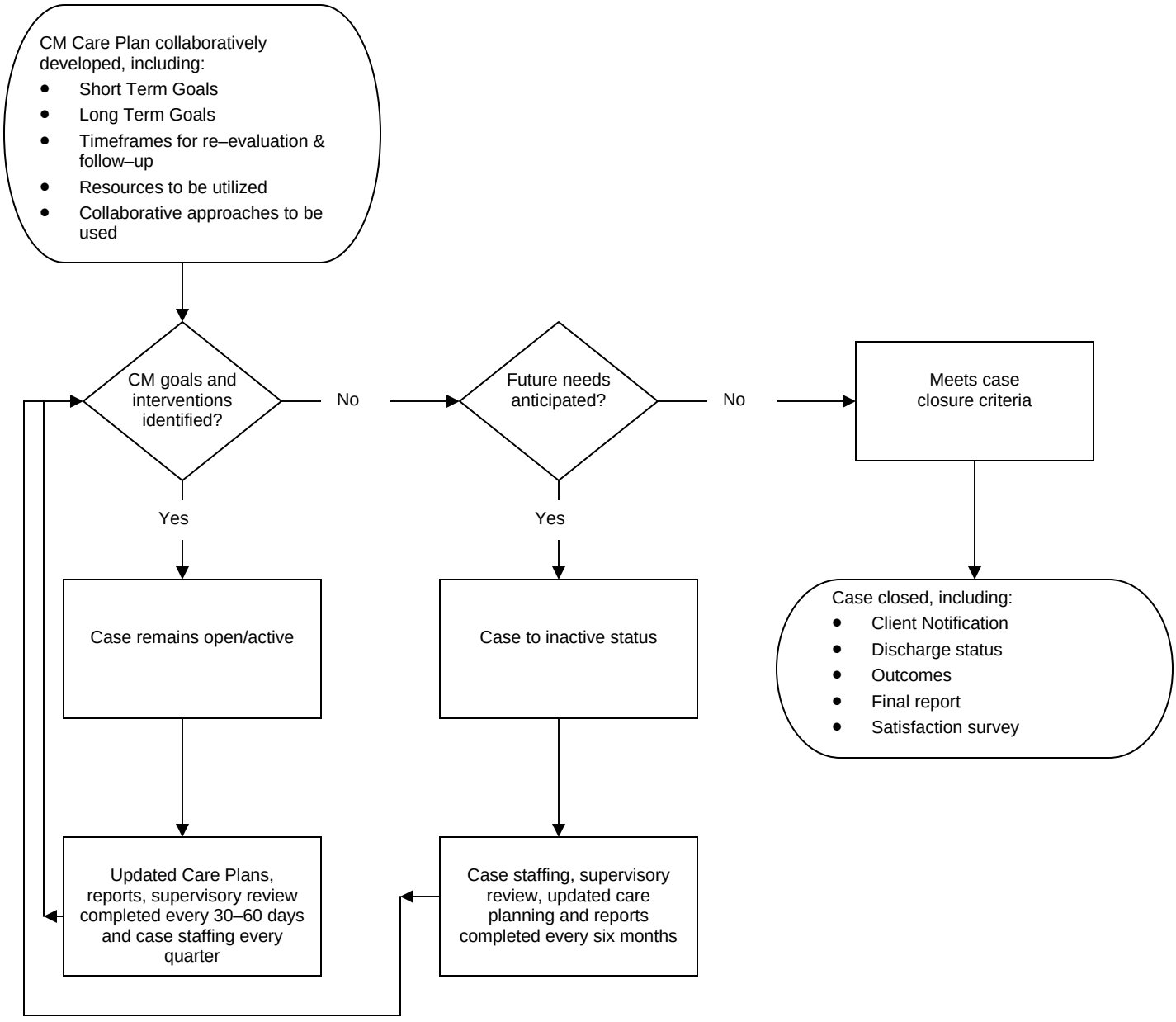
Exhibit 21



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APPENDIX A

Select Pre–authorization List of Diagnoses and Procedures for Idaho Medicaid and Division of Family and Community Services Clients

Approved List of V–Codes That May Be Used for Principal Diagnoses

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Select Pre-Authorization List of Diagnoses and Procedures

FOR IDAHO MEDICAID
AND DIVISION OF FAMILY AND COMMUNITY SERVICES CLIENTS
Revised November 2005

PRE-AUTHORIZATION LIST REQUIRING QUALIS HEALTH REVIEW
Phone 1 800-783-9207 Fax 1 800-826-3836
All surgical procedures on this list require pre-authorization for inpatient and outpatient services.

Procedure	ICD-9-CM Code October 2005	CPT® Code January 2006
Arthrodesis (Spinal Fusion) **Note: Artificial disc not a covered benefit.**	78.59 81.00 through 81.08 81.30 through 81.39 **81.61(not valid 10/01/05)**, 81.62, 81.63, 81.64	22548, 22554, 22556, 22558, 22585, 22590, 22595, 22600, 22610, 22612, 22614, 22630, 22632, 22800, 22802, 22804, 22808, 22810, 22812, 22830, 22840, 22841, 22842, 22843, 22844, 22845, 22846, 22847, 22848, 22849, 22851, 27280
Unlisted neck, thorax procedure	78.41	21899
Unlisted spine procedure	78.71	22899
Laminectomy/Diskectomy Laminoplasty	03.02 03.09 03.1 03.6 80.50 80.51	63001, 63003, 63005, 63011, 63012, 63015, 63016, 63017, 63020, 63030, 63035, 63040, 63042, 63043, 63044, 63045, 63046, 63047, 63048, 63050, 63051, 63055, 63056, 63057, 63064, 63066, 63075, 63076, 63077, 63078, 63172, 63173, 63180, 63182, 63185,63190, 63191, 63194, 63195,63196,63197, 63198, 63199, 63200
Hysterectomy		
Abdominal	68.3, 68.31, 68.39	58180, 59135, 59525 58150, 58152, 58200, 58951, 59135, 59525
	68.4	58210
	68.6	58550, 58260, 58262, 58263, 58267, 58270,
Vaginal	68.51 68.59	58275, 58280**,** 58285, 58290, 58291, 58292, 58293, 58294
Laparoscopic	68.7	58953, 58954
Radical		
Other and Unspecified	68.9	
Reduction Mammoplasty		
Unilateral, Bilateral	85.31, 85.32	19318
Total Hip Replacement	81.51	27130
Revision	81.53 **00.70–0076 (effective 10/1/05)**	27132, 27134, 27137, 27138
Partial Hip Replacement	81.52	27125
Total Knee Replacement	81.54	27445, 27446, 27447
Revision	81.55 **00.80–00.84 (effective 10/1/05)**	27486, 27487

Procedure	ICD-9-CM Code October 2005	CPT® Code January 2006
Transplants		
Bone Marrow Transplant		
Autologous	41.00, 41.01, 41.04, 41.07, 41.09	38241
Allogenic	41.02, 41.03, 41.05, 41.06, 41.08	38240, 38242
Liver Transplant **Note: Liver from live donor not a covered benefit**	50.59	47135, 47136, 1/1/05 47143, 47144, 47145, 47146, 47147
Kidney Transplant	55.61 55.69	50380 50360, 50365, 1/1/05 50323, 50325, 50327, 50328, 50329
Intestinal Transplant	46.97	44133, 44135, 44136, 44715, 44720,44721
Heart Transplant (Note: Transplant facilities must be Medicare approved.)	37.5, 37.51, 37.52, 37.53, 37.54	33945
Bariatric Surgery	44.31	43644, 43645, 43845, 43846, 43847, 43848
Panniculectomy	86.83	15831, 15877
Alcohol and Drug Rehabilitation and Detoxification **Inpatient Only**		
Alcohol Rehabilitation	94.61	90899
Alcohol Detoxification	94.62	90899
Alcohol Rehabilitation and Detoxification	94.63	90899
Drug Rehabilitation	94.64	90899
Drug Detoxification	94.65	90899
Drug Rehabilitation and Detoxification	94.66	90899
Combined Alcohol and Drug Rehabilitation	94.67	90899
Combined Alcohol and Drug Detoxification	94.68	90899
Combined Alcohol and Drug Rehabilitation and Detoxification	94.69	90899
Psychiatric Admissions (Diagnosis Codes) Inpatient Only	291.0 through 314.0	
Physical Rehabilitation Care involving use of rehabilitation procedures Inpatient Only	V57 (Diagnosis Code) This includes admission to all rehabilitation facilities, regardless of diagnosis.	

Approved List of V-Codes That May Be Used for Principal Diagnoses

The V-Codes in the current ICD-9 CM book, Tabular List for V-Codes, listed as acceptable codes for use as a principal diagnosis will be used for pre-authorization and concurrent review purposes.

Only these V-Codes will be accepted by the Qualis Health nurse reviewers when performing pre-authorization or concurrent review for Idaho Medicaid clients.

APPENDIX B

Glossary

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Glossary

- **AIM/MMIS:** Idaho Medicaid's Management Information System
- **ANDs:** Administratively Necessary Days
- **Call date or Call–back date:** Notification date or date the review is conducted (same as "Review Date" or "Scheduled Discharge Date")
- **Care Management Department:** Includes the telephonic utilization and medical record review areas as well as case management services at Qualis Health
- **Case ID Number *(previously certification or reference number*):** Qualis Health number assigned to each review certified; number used on all billing or claims forms for the fiscal agent to verify the pre–certification
- **CM:** Case Manager at Qualis Health
- **CMS:** Center for Medicare and Medicaid Services (formerly **HCFA**, Health Care Financing Agency)
- **Client:** An individual eligible for benefits under Idaho Medicaid or FACS programs; may also refer to agencies which have contracts with Qualis Health, such as the Department
- **Client ID Number:** Medicaid or FACS Identification number
- **Concurrent:** Review of continued hospital stay
- **CPT®:** Physicians' Current Procedural Terminology
- **DD:** Developmental Disability Waiver Program
- **Department:** Department of Health and Welfare
- **DHW:** Department of Health and Welfare
- **DOB:** Date of birth
- **DS:** Discharge screening criteria indicative of patient stability and readiness for discharge
- **EDS:** Electronic Data Systems Corp., claims payer or fiscal agent for Idaho Medicaid
- **FACS:** Family and Children's Service, Division of Family and Community Services. Clients in the legal custody or legal guardianship of the State
- **HCIA:** Health Care Investment Analyst, Inc.
- **HIPAA:** Health Insurance Portability and Accountability Act, relating to the uses and disclosures of Protected Health Information (PHI)
- **ICD–9–CM:** International Classification of Diseases© (9th Edition, Clinical Modification)
- **IMD:** Institution for Mental Disease
- **Ineligible Non–Citizen:** A legal or illegal non–citizen who is eligible only for medical services necessary to treat an emergency medical condition, which can reasonably be expected to seriously harm the patient's health, cause serious impairment to bodily functions or cause serious dysfunction of any bodily organ part without immediate medical attention.

- **IPA Number:** Internal Pre–certification Number assigned to each review by the EDS system, linked to the Qualis Health Case ID number in AIM
- **IS:** Intensity of Services. Diagnostic and therapeutic services that can be provided only in a hospital
- **InterQual® Criteria:** Evidence based clinical review criteria and guidelines which support first level clinical review by Qualis Health nurse reviewers and case managers (non–physician review).
- **LOC:** Level of Care
- **LOS:** Length of Stay
- **MAVIS:** Medicaid Automated Voice Information System
- **Non–certification:** Decision not to authorize a service
- **Non–urgent Procedure:** Procedure that is subject to the choice or decision of the patient or physician regarding medical services that are advantageous to the patient but not necessary to prevent the death or disability of the patient
- **NR:** Nurse Reviewer at Qualis Health
- **P/PC:** Physician/Practitioner Consultant for Qualis Health
- **Pre–service Review:** A certification review conducted prior to a hospital admission or outpatient procedure
- **Provider:** An individual, firm, corporation, association, or institution providing or approved to provide medical services to a DHW client (Medicaid or FACS)
- **Provider I.D. Number:** Number assigned to each provider by Idaho Medicaid's fiscal agent, EDS, for use in submitting claims
- **QIO:** Quality Improvement Organization
- **Retroactive or Retroactive Eligibility Review:** Review performed for a client who was not Medicaid eligible at the time of admission and was determined eligible at a later date
- **Retrospective Review:** A type of post–payment and/or post–admission review; client may or may not be eligible at the time of admission
- **Review Date:** Notification date or date review required (same as "Call Back Date" and "Scheduled Discharge Date")
- **RMHA:** Regional Mental Health Authority
- **RULE:** Inpatient psychiatric services– IDAPA 16.03.09.079
  Inpatient hospital services– IDAPA 16.03.09.080
  Physician services– IDAPA 16.03.09.070
- **Scheduled Discharge Date:** Notification date or date review required (same as "Review Date" or "Call Back Date")
- **SI:** Severity of Illness. Objective clinical findings that define severity of illness
- **SURS:** Surveillance and Utilization Review Services. Unit within the Department of Health and Welfare, which investigates quality of care concerns, utilization of services and payment issues

- **Urgent Care Case:** Any request for a utilization management determination with respect to which the application of the time periods for making non–urgent care determinations a) could seriously jeopardize the life or health of the client or the ability of the client to regain maximum function, or b) in the opinion of a physician with knowledge of the client's medical condition, would subject the client to severe pain that cannot be adequately managed without the care or treatment that is the subject of the case.

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APPENDIX C

List of Key Contact Personnel for Qualis Health and Idaho DHW

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Qualis Health Key Contact Personnel

Seattle Office

Care Management Department
10700 Meridian Avenue North, Suite 100
P.O. Box 33400
Seattle, WA 98133
Tel.: (800) 783-9207
Fax: (800) 826-3836

CARE MANAGEMENT DEPARTMENT

Operational Staff:

Cara Robinson, RN, BSN, CCM
Director, Medicaid Services
(206) 368-2429
E-mail: carar@qualishealth.org

PROGRAM:
Utilization Review & Case Management

Linda Peake, RN
Manager, Medicaid Services
(206) 364-9700, extension 2276
E-mail: lindap@qualishealth.org

PROGRAM:
Utilization Review

Christine Griggs, RN, BSN, CCM, CPUR
Manager, Specialty Review
(206) 364-9700, extension 5562
E-mail: christineg@qualishealth.org

PROGRAM:
Appeal Review
Focused Case Review

Chad Heely, RN, CCM
Case Manager
(206) 440-2654
(866) 776-2805, extension 2237
E-mail: chadh@qualishealth.org

PROGRAM:
Case Management

Nicole Kline, RN, BSN
Case Manager
(206) 368-2384
(866) 776-2805, extension 2384
E-mail: nicolek@qualishealth.org

PROGRAM:
Case Management

Kathleen Parry, RN
Case Manager
(206) 364-9700, extension 2279
E-mail: kathleenp@qualishealth.org

PROGRAM:
Case Management

Annette Lowey, RN, BSN
Case Manager
(206) 364-9700, extension 2223
E-mail: annettel@qualishealth.org

PROGRAM:
Case Management

Medical Affairs

Lydia Bartholomew, MD, MHA, CPE
Senior Medical Director
(206) 364-9700, extension 2648
E-mail: lydiab@qualishealth.org

PROGRAM:
Physician Review

Elsie Crandell
Executive Assistant, Medical Affairs
(206) 364-9700, extension 2473
E-mail: elsiec@qualishealth.org

PROGRAM:
Medical Affairs

Administrative Staff

Marci Weis, RN, MPH, CCM
Vice President, Care Management Department
(206) 440-2658
E-mail: marciw@qualishealth.org

PROGRAM:
All Review Programs

Carol Kulseth, RN, BSN
Contract Administrator
(206) 368-2404
E-mail: carolk@qualishealth.org

PROGRAM:
All Review Programs

State of Idaho Key Contact Personnel

Department of Health and Welfare

Division of Medicaid

Phone: 208-334-5747

Mailing Address:
P.O. Box 83720
Boise, Idaho 83720-0036

Office Location:
3232 Elder Street
Boise, Idaho 83705

Paul Leary, Bureau of Medical Care **E-mail: LearyP@idhw.state.id.us**	Bureau Chief, Medical Care	(208) 364-1831 FAX (208) 332-7285
Arlee Coppinger, CPC Primary Care **E-mail: CoppingA@idhw.state.id.us**	Medical Program Specialist	(208) 287-1177 FAX (208) 332-7280
Donald Norris, MD Division of Medicaid **E-mail: NorrisD@idhw.state.id.us**	Medical Director	(208) 332-7952 FAX (208) 364-1811
Terry Gipson, MD Division of Medicaid **E-mail: GipsonT@idhw.state.id.us**	Associate Medical Director	(208) 334-5747 FAX (208) 364-1811
Barbara Hyde, RN, BSN Primary Care **E-mail: hydeb@idhw.state.id.us**	Primary Care Co-Manager: Complex Case Coordination (CCM), Disease Management	(208) 364-1835 FAX (208) 332-7280
Steve Brown, LPN Primary Care **E-mail: BrownS3@idhw.state.id.us**	Primary Care Co-Manager: CCM, Physical Therapy, DME	(208) 364-1989 FAX (208) 332-7280
Carolyn Zigon RN Primary Care **E-mail: ZigonC@idhw.state.id.us**	AN Days, Surgery Pre-Authorization, PET Scans, Complex Case Management, Non-Citizen Emergency Srvs	(208) 364-1904 FAX (208) 332-7280
Patty Fleming LPN Primary Care **E-mail: FlemingP@idhw.state.id.us**	Vision Pre-Authorization, Breast / Cervical Cancer Program, Creditable Insurance	(208) 332-7955 FAX (208) 332-7280
Arla Farmer, RN Medicaid Policy Alternative Care Coordinator **E-mail: FarmerA@idhw.state.id.us**	Policy for Hospital, Physician, Hospice, TBI, Pregnant Women, Home Health, Dental	(208) 364-1958 FAX 332-7285
Jeanne Siroky, RN, Medical Program Specialist **E-mail: SirokyJ@idhw.state.id.us**	Policy for: Durable Medical Equipment (DME), Pharmacy	(208) 364-1897 FAX 332-7280
Anna Bodine, RN Primary Care **E-mail: BodineA@idhw.state.id.us**	Hospice DME	(208) 364-1830 866 205-7403 (toll free) FAX: (208) 332-7280
Medicaid Fraud Hotline (toll free)		(866) 635-7515

Electronic Data System Corporation

P.O. Box 23
Boise, Idaho 83707

Questions regarding:

- Claims Issues
- Provider Enrollment
- Client Eligibility, Limitations, Restrictions
- Services requiring prior authorization
- Technical support for electronic transaction

Medicaid Automated Voice Information System
(MAVIS): (800) 685-3757
LOCAL: (208) 383-4310

FAX: (208) 395-2030
Client Help Line 888-239-8463

APPENDIX D

Bulletins

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATION RELEASE 2006-07
March 15, 2006

TO: Hospital Administrators

FROM: Leslie M. Clement, Deputy Administrator

SUBJECT: **NOTICE OF 2006 MEDICAID RATES FOR SWING-BED DAYS AND ADMINISTRATIVELY NECESSARY DAYS (AND)**

Effective for dates-of-service on or after January 1, 2006, Medicaid will pay the following rates:

Swing-Bed Day	$187.25
Administratively Necessary Day (AND)	$153.61

If you have already billed for swing-beds days since 01/01/06, please submit corrected claim adjustments to EDS in order to receive reimbursement with the new rate listed above.

If you have any questions concerning the information contained in this release, please contact Eric Anderson, Senior Financial Specialist for the Division of Medicaid, at (208) 364-1918.

Thank you for your continued participation in the Idaho Medicaid Program.

LC/ea/sw

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATION RELEASE MA05-41
January 1, 2006

TO: Physicians, Osteopaths, Anesthesiologists, Mid-level Practitioners, Hospitals, and Ambulatory Surgical Centers

FROM: Leslie M. Clement, Deputy Administrator

SUBJECT: **CHANGES IN PRIOR AUTHORIZATION REQUIREMENTS FOR SPINAL NEUROSTIMULATORS**

Effective for dates of service on or after 02/01/2006, prior authorization will be required for implantation of *spinal* neurostimulators. This includes all services, supplies, facility, and ancillary charges related to implantation of spinal neurostimulators with the following codes:

ICD-9 Procedures and Interventions code 03.93, (*Implantation or replacement of spinal neurostimulator lead(s*), including all services related to inpatient, outpatient, and ambulatory surgical center charges for services.

CPT procedure codes 63650, 63655, 63660, 63685, and 63688

To request prior authorization for implanted *spinal* neurostimulators:

- Submit a *Surgery Prior Authorization Request* form, which is available online at: http://www.healthandwelfare.idaho.gov/Portals/_Rainbow/Documents/medical/s6d_forms.pdf
- Follow the procedures in Section 2.3 of the Medicaid provider manual, which is available online at: http://www.healthandwelfare.idaho.gov/Portals/_Rainbow/Documents/medical/s2_gen_billing.pdf
- Include the following documentation when submitting a request for prior authorization:
  other, less invasive procedures that are contraindicated, or have been attempted without success;
  client has received a multidisciplinary team screening and evaluation;
  client has received a psychological evaluation; and
  when requesting prior authorization for permanent implanted spinal neurostimulators, document that relief of pain has been demonstrated with a temporary implanted electrode(s).

PROVIDER HANDBOOK:
This information release changes information in the following section(s) of the Idaho Medicaid Provider Handbook:
Physician/osteopath handbook, Section 3.3.3.6, which is available online at:
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/s3_004_005_physician.pdf
Hospital handbook, Section 3.4.13 through 3.4.15, which is available online at:
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/s3_001_hospital.pdf

If you have questions concerning this Information Release, please contact Arla Farmer, Bureau of Medical Care, at (208) 364-1958 or by FAX at (208) 332-7285.

Thank you for your continuing participation in the Medicaid Program.

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATION RELEASE 2005-39
November 1, 2005

TO: **ALL COMMERCIAL & AGENCY NON-EMERGENT TRANSPORTATION (NET) PROVIDERS**

FROM: **LESLIE M. CLEMENT, DEPUTY ADMINISTRATOR**

SUBJECT: **NEW CONTACTS FOR REQUESTING NON-EMERGENT TRANSPORTATION PRIOR AUTHORIZATION**

NEW CONTACTS
We are making some organizational changes in order to better respond to your requests. Beginning November 14, 2005, we will ask that you direct your requests for prior-authorization in the following manner.

For transportation to developmental disability and mental health services, contact:
Dori Boyle, local calls (208) 287-1172 OR long distance 1-800-296-0509 # 1172.
BoyleD@idhw.state.id.us
FAX number: 208-334-4979 or 1-800-296-0513

For transportation to all other non-emergent medical transportation requests and out-of-state transportation contact:
Sara Hunt, local calls (208)287-1173 OR long distance 1-800-296-0509 # 1173.
HuntS@idhw.state.id.us
FAX number: 208-334-4979 or 1-800-296-0513

EXISTING BLANKET AUTHORIZATIONS
Existing blanket authorizations will remain valid regardless of the transportation coordinator they were originally submitted to.

GRACE PERIOD
These changes will take effect on November 14, 2005. The Division will allow a two-week transition period after that date. If you send the wrong type of request to the transportation coordinators within the transition period, the request will be accepted, however, instructions will be sent to you regarding the person it should be directed to in the future. After the transition period, your request will be returned to you without being processed. It will be your responsibility to re-send the requests to the correct coordinator within 24 hours.
If you have any questions regarding this information release, please contact the appropriate Transportation Coordinator listed above. Thank you for your continued participation in the Idaho Medicaid Program.

IDAHO MEDICAID PROVIDER HANDBOOK
This Information Release is incorporated into the current Idaho Medicaid Provider Handbook.

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATION RELEASE MA05-22
June 22, 2005

TO: **PHYSICIANS, MID-LEVEL PRACTITIONERS, AND HOSPITALS**

FROM: **LESLIE M. CLEMENT, DEPUTY ADMINISTRATOR**

SUBJECT: **CHANGE IN MEDICAID COVERAGE FOR MALE CIRCUMCISION**

Effective with dates of service on or after 8/1/2005, Medicaid will only cover male circumcisions which are *medically necessary*. Circumcisions performed for religious or cultural preferences will not be covered.

How to bill Medicaid for *medically necessary* circumcisions:
Claims billed with CPT (Current Procedural Terminology) circumcision codes **54150, 54152, 54160** and **54161,** and related charges such as medications, supplies, equipment, and treatment rooms will require the provider to include documentation of medical necessity. Documentation may be a note in the comments field of the claim, or an attachment to the claim.

***Medically necessary* circumcisions *do not* require Prior Authorization:**
Valid diagnoses indicating medical necessity for a circumcision include recurrent balanoposthitis, recurrent urinary tract or localized infections, recurrent lesions, trauma, or malignancy.

If a client has a different diagnosis than those listed above and the provider wants approval from Medicaid prior to performing the circumcision, the provider may submit a *Request for Prior Authorization* following the procedures in the Medicaid Provider Handbook, General Billing Section 2.3, that is available online at:
http://www.healthandwelfare.idaho.gov/Portals/_Rainbow/Documents/medical/s2_gen_billing.pdf
The Prior Authorization form is available online at:
http://www.healthandwelfare.idaho.gov/Portals/_Rainbow/Documents/medical/s6d_forms.pdf
Requests for Prior Authorization should be sent to:

Division of Medicaid
EPSDT Coordinator
Bureau of Care Management
P.O. Box 83720
Boise, ID 83720-0036
FAX: (208) 364-1864 Phone: (208) 364-1842

Billing the parent(s) or responsible party for circumcisions performed on or after August 1, 2005:
A provider may bill the parent(s) or responsible party directly for the charges related to the circumcision if the provider informs the parent(s) or responsible party, *before the procedure is performed*, that Medicaid will not cover routine circumcisions. For additional information about Medicaid Non-Covered Services please refer to General Section 1.3.3.1 of the Medicaid Provider Handbook, which is available on line at:
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/s1_gen_info.pdf

It is not necessary to obtain a denial from Medicaid before billing the parent(s) or responsible party for routine circumcisions. Billing Medicaid for non-covered routine circumcisions will cause your entire claim to pend for manual review, causing an unnecessary delay in processing.

If you have questions concerning this Information Release, please contact Ms. Arla Farmer, Bureau of Medicaid Policy, at (208) 364-1958 or by FAX at (208) 334-2465.

Thank you for your participation in the Medicaid program.

IDAHO MEDICAID PROVIDER HANDBOOK:
This Information Release changes information in the Physician/Osteopath Section 3.2.5 of the Idaho Medicaid Provider Handbook, available online at:
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/s3_004_005_physician.pdf
and the Hospital Section 3.6.2 of the Idaho Medicaid Provider Handbook, available online at:
http://www.healthandwelfare.idaho.gov/_Rainbow/Documents/medical/s3_001_hospital.pdf

LC/af

IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATION RELEASE 2005–10
March 15, 2005

TO: HOSPITAL ADMINISTRATORS

FROM: Leslie M. Clement, Acting Deputy Administrator

SUBJECT: NOTICE OF 2005 MEDICAID RATES FOR SWING–BED DAYS AND ADMINISTRATIVELY NECESSARY DAYS (AND)

Effective for dates–of–service on or after January 1, 2005, Medicaid will pay the following rates:

Swing–Bed Day	$182.01
Administratively Necessary Day (AND)	$147.81

If you have already billed for swing–bed days since 01/01/05, please submit corrected claim adjustments to EDS in order to receive reimbursement with the new rate listed above.

If you have any questions concerning the information contained in this release, please contact Sheila Pugatch, Senior Financial Specialist for the Bureau of Medicaid Policy, at (208) 364-1817.

Thank you for your continued participation in the Idaho Medicaid Program.

LC/sp/jr

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATIONAL LETTER 2005–06
January 20, 2005

TO: **PHYSICIANS**

FROM: **Randy May, Deputy Administrator**

SUBJECT: **HIGH RISK PREGNANCY CASE MANAGEMENT**

High risk pregnancy case management services are now available to support you in caring for Idaho Medicaid patients. Pregnant women, who are at risk for premature labor or congenital issues of the fetus, may be referred to a Qualis Health Nurse Case Manager, who will telephonically assist with the coordination of in–home and community support services. To make a referral:

Contact Qualis Health at 1-800-783-9207 and request case management services
A nurse case manager will send a packet of information to the patient with information about the voluntary, no–cost service.
If the patient wishes to participate, she will return the signed form to Qualis Health.

If you have questions please contact Arlee Coppinger at 208 287-1177.

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATION RELEASE 2004–61
December 23, 2004

NOTE: See information in the February 2005 Medicaid Bulletin entitled "Additional Contact Information for IR 2004–61" which has been incorporated herein.

TO: HOSPITAL PROVIDERS OF INPATIENT MENTAL HEALTH SERVICES

FROM: Leslie M. Clement, Deputy Administrator

SUBJECT: ADDITION OF LIMITED INPATIENT MENTAL HEALTH SERVICES FOR CHIP–B PARTICIPANTS

The Children's Health Insurance Program B (CHIP–B) was implemented in July 1, 2004. CHIP–B provides a limited benefit package to qualified children and was implemented without an inpatient mental health benefit.

Effective immediately, a limited amount of inpatient mental health services are added to the CHIP–B benefit package. Medicaid/CHIP will now reimburse up to thirty (30) days of inpatient mental health services per calendar year provided to CHIP–B participants. This change is retroactive and applicable to services provided on or after July 1, 2004 to CHIP–B participants.

What you need to do: If you have provided inpatient mental health services to a CHIP–B participant since July 1, 2004, please request a retrospective review from Qualis Health to establish medical necessity for the inpatient stay. The medical necessity criteria are the same for CHIP–B as for regular Medicaid (see IDAPA 16.03.09.079). Once a prior authorization number is issued, you can bill Idaho Medicaid using the usual claim process. Penalties for late reviews will be waived if the services were provided prior to the date of this notice.

After January 1, 2005, all Medicaid provisions for inpatient mental health services, including penalties for late review, will apply.

For questions regarding the review process, please refer to the Idaho Medicaid Provider Manual, Section X. Psychiatric Review at **www.qualishealth.org** or call Qualis Health at 1-800-783-9207. If you have questions regarding benefits and billing, please contact EDS at 1-800-685-3757 or in the Boise area at 383-4310. Thank you for your continued participation in the Idaho Medicaid Program.

IDAHO MEDICAID PROVIDER HANDBOOK:

This Information Release amends information in the following section of your Idaho Medicaid Provider Handbook: Appendix B: CHIP–B dated July 1, 2004.

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATION RELEASE #2004–53
December 17, 2004

TO: ALL GENERAL ACUTE HOSPITALS

FROM: Randy May, Deputy Administrator

SUBJECT: EXPEDITED MEDICAID ELIGIBILITY FOR CERTAIN NEWBORNS

The enclosed form "Notification of Birth: Anticipated Stays Greater Than 72 hours" was developed to assist hospitals in notifying the Department of Health and Welfare of births that may be covered by the Idaho Medicaid program. Use of this form will expedite Medicaid eligibility for certain newborns under the following circumstances:

- When a newborn has a length of stay greater than 72 hours;
- When a newborn that was discharged under 72 hours requires re–admission to the hospital, and the Medicaid Automated Voice Information System (MAVIS) does not reflect an open Medicaid eligibility status.

This form is also available on the Department's website at: **www.healthandwelfare.idaho.gov**. Go to "I want help with" and click on **Medicaid Provider Information.** Under "Other Resources" click on **Information Releases**, then under "Attachments" click on **2004–53** or you may click HERE to obtain a copy.

If you have questions regarding this information release, please contact Arlee Coppinger at 208-287-1177. Thank you for your continued participation in the Idaho Medicaid Program.

IDAHO MEDICAID PROVIDER HANDBOOK
This Information Release replaces information in the following section of your Idaho Medicaid Provider Handbook dated June 1, 2004: Section 3.2.7.2 Hospital – Birth/Delivery Billing.

RM/ac

Enclosure

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATIONAL LETTER 2004–58
November 26, 2004

TO: IDAHO MEDICAID HOSPITAL DISCHARGE PLANNERS
IDAHO INFANT TODDLER PROGRAM

FROM: Randy May, Deputy Administrator

SUBJECT: EXPANSION OF THE UM/CM NEONATE PROGRAM TO ALL HOSPITALS

Since July 2004, Qualis Health has conducted a pilot program for the neonatal population with three Idaho Medicaid facilities. The Neonate Program integrates Utilization Management (UM) and Case Management (CM) services for the neonatal population of select Idaho Medicaid clients. One nurse case manager from Qualis Health performs both the UM and CM functions for those babies who meet specific clinical criteria.

Effective December 1, 2004, the Neonate UM/CM Program will be expanded to include all Idaho Medicaid hospital providers. You will be contacted by a Qualis Health Nurse Case Manager regarding babies in your facilities who meet criteria. The CM nurse will assist with discharge planning and in–home/community supports.

Questions regarding this letter may be directed to Arlee Coppinger, Contract Officer, at 208-287-1177**.**

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATIONAL LETTER 2004–57
November 26, 2004

TO: PHYSICIANS

FROM: Randy May, Deputy Administrator

SUBJECT: BARIATRIC SURGERY, PANNICULECTOMY/ABDOMINOPLASTY

Effective December 1, 2004, prior authorization for Bariatric Surgery (Gastric Bypass) and Panniculectomy/Abdominoplasty will be conducted by Qualis Health. Eligibility and documentation requirements remain the same.

To submit prior authorization requests to Qualis Health, please call 800-783-9207, ext. 2. Required documentation may be mailed or faxed to:

Qualis Health
10700 Meridian Ave. N., Suite 100
PO Box 33400
Seattle, WA. 98133
Fax 800-826-3836
Attn.: Idaho Medicaid Contract

Questions regarding this letter may be directed to Arlee Coppinger, Contract Officer, at 208-287-1177.

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATION RELEASE 2004–27
June 1, 2004

TO: ALL MEDICAID PROVIDERS

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: CHIP–B BENEFIT PACKAGE AND BILLING INSTRUCTIONS

Effective July 1, 2004, Idaho Medicaid will implement the new Idaho Title XXI Children's Health Insurance Program–Part B (CHIP–B).

CHIP–B is a basic health care program, administered by the State that pays for primary health care services for children. CHIP–B was created in response to legislation enacted by the 2003 Idaho Legislature. The intent of this legislation is to increase the availability of affordable, basic health care insurance to currently uninsured children who live in families with gross annual income between 150% – 185% of the Federal Poverty Guideline (FPG).

The CHIP–B program offers limited medical coverage to qualified applicants. **Covered** services include:

Hospital services (inpatient and outpatient)

Limited Clinical services (Mental Health Clinics, Regional Mental Health Clinics, and Diabetes Clinics)

Physician, Osteopath, and Mid–Level Practitioner services

Vision services

Prescription drugs

Laboratory services

Emergent Ambulance/Air Ambulance services

Rehabilitative Option for Rehab Mental Health services

Essential Care services (District Health Departments, Indian Health Services Clinics, Rural Health Clinics)

Federally Qualified Health Center services

Birthing Center services

Radiology Technical services (Mobile x–rays)

Hearing services (Audiologist and Hearing Aid Vendors)

CHIP–B services will be reimbursed at the current Medicaid reimbursement rate and are subject to all current billing requirements, edits, and limitations for services under the regular Medicaid program. The following is a list of **non–covered** services for CHIP–B clients:

All Inpatient Psychiatric services

Transplant services of any kind

Clinic services (Diagnostic, PWC, Speech and Hearing Clinic Services)

Dental services

Unit Dose Pharmacy services

Home Health services

Non–emergent transportation services (Commercial, Individual, Agency and Non–Medical Waiver Transportation)

Long Term Care services

Hospice services

Rehabilitative Option for Developmental Disability Centers and School Based services

Durable Medical Equipment and Supply services

All Waiver services (Personal Care Services, Nursing Services, DD, TBI and ISSH)

Case Management services

Chiropractic services

Dietician services

Physical Therapy services

Podiatry services

Social Worker services

Medicare Crossover Claims

SPECIAL BILLING INSTRUCTIONS

Coverage Changes and Claim Billing

If a participant changes their coverage from CHIP–B to Medicaid or from Medicaid to CHIP–B, charges must be billed on separate claims for payment. A claim which includes both CHIP–B and Medicaid services will be denied. For example, if the participant had CHIP–B coverage in July and then Medicaid coverage in August, the July CHIP–B services must be billed on one claim. The Medicaid services in August must be billed on a separate claim.

Previous Prior Authorizations

Previous prior authorizations are not a guarantee of payment if the client's eligibility changes from Medicaid to CHIP–B. Prior authorizations received under Medicaid will not be valid for CHIP–B if the service is not covered under CHIP–B. For example: a participant has a current prior authorization for non–medical transportation for the months of July and August. The participant has Medicaid coverage in July and CHIP–B in August. The non–medical transportation services rendered in July would be covered by the prior authorization, but the August services would not be covered because the client was no longer eligible for the same level of benefits under the CHIP–B program.

Healthy Connections

As with Medicaid, the Department requires most CHIP–B participants to enroll and participate in the Healthy Connections Case Management program. If you have questions about the Healthy Connections program in your area, contact your local Healthy Connections Representative. Healthy Connections Representatives' contact numbers are published in the Provider Handbook and the Medicaid newsletter.

Claim Submission

Electronic CHIP–B claims should be sent to EDS using HIPAA compliant billing software the same way electronic Medicaid claims are sent today. Send CHIP–B paper claims to EDS, P.O. Box 23, Boise, ID 83707–0023. If you have questions about claims processing for CHIP–B participants, contact EDS at 1-800-685-3757 or in the local Boise area at 383-4310.

Additional Information

Additional information about the CHIP–B program can be found by selecting the CHIP link on the Idaho Department of Health and Welfare Website at http://www.idahohealth.org.

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATION RELEASE MA04–10
February 2, 2004

TO: ALL MEDICAID PROVIDERS

FROM: Randy May, Deputy Administrator

SUBJECT: HIPAA ELECTRONIC PRIOR AUTHORIZATION (PA) TRANSACTION AVAILABLE FEBRUARY 23, 2004

Idaho Medicaid will implement the HIPAA 278 transaction (electronic request and response for prior authorization of services) **on February 23, 2004** as part of the Department's HIPAA compliance activities.

Medicaid will not eliminate or change current procedures for requesting a PA.

The HIPAA 278 PA transaction is **optional** for providers.

Software

Idaho's Provider Electronic Solutions (PES) software doesn't support the HIPAA 278 PA transaction. Providers who use the HIPAA 278 PA transaction must purchase software from a private vendor that supports the transaction in the required HIPAA format. Software vendors are encouraged to test the transaction with EDS before providers use the software.

When a HIPAA 278 PA request is received, the Department or its designee will make a prior authorization decision, translate it into the required electronic HIPAA format, and send it back to the provider's software. Providers will retrieve the PA response according to the instructions of their software vendor.

When Attachments are Required

The HIPAA electronic PA request doesn't include a method for submitting electronic attachments. Providers who choose to use the HIPAA 278 transaction should submit required attachments on paper using current procedures specified in the Provider Handbook, which is available online at: http://www2.state.id.us/dhw/medicaid/provhb/. Additionally, providers must send a completed **Electronic PA Request Attachment Cover Sheet** on the front of each attachment, which will be used to match the attachment to the correct electronic PA request. The electronic PA request will be denied if a required attachment is not received according to the timeframes established by the program. A copy of the **Electronic PA Request Attachment Cover Sheet** form is included in this Information Release. Please copy this form for future use.

For questions regarding billing requirements, please contact EDS at 1-800-685-3757. Thank you for your continued participation in the Idaho Medicaid Program.

RM/af

Idaho Medicaid
Electronic PA Request Attachment Cover Sheet

Complete and submit this cover sheet with the required attachment when you submit an electronic HIPAA formatted Prior Authorization Request (HIPAA 278 transaction). We will match the information on this cover sheet with your electronic PA request.

This cover sheet is not required for PAs that are not requested electronically.

Please provide the following information:

Prior Authorization Control # Note – This number must match the control number required on the PA request	
Date electronic PA request was submitted	
Provider Name	
Provider 9–digit ID Number	
Client Name	
Client's 7–digit Medicaid ID Number	
Date(s) of Service	

Please Copy this Form for Future Use

IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATION RELEASE 2003–72
August 22, 2003

TO: HOSPITAL PROVIDERS

FROM: Kathleen P. Allyn, Deputy Administrator

SUBJECT: REVENUE CODE 400 FOR PET SCANS UNTIL OCTOBER 20, 2003 CESAREAN SECTIONS LENGTH OF STAY POLICY EFFECTIVE SEPTEMBER 1, 2003

Positron Emission Tomography

Effective for dates of service on or after **August 1, 2003 through October 19, 2003** when reporting a Positron Emission Tomography (PET) providers will need to report with Revenue code **400** (other imaging services) instead of 404 (positron emission tomography). Effective for dates of service on or after **October 20, 2003**, providers will again bill with Revenue code **404**.

Currently, revenue code 404 does not allow providers to bill the technical or professional components separately; therefore, by billing revenue code 400, providers can bill the components individually. As of October 20, the Medicaid pricing system will be able to process PET scans under revenue code 404. When reporting a PET scan, the appropriate HCPCS must be included on the claim form. Please see attached for a list of covered PET scan HCPCS codes. PET scans billed with a CPT code will be denied.

PET scans require authorization from the Bureau of Care Management prior to services being rendered. For questions regarding prior authorizations, please call (208) 364-1824. Prior Authorization requests must be faxed to (208) 364-1864 or mailed to Idaho Medicaid, Bureau of Care Management, P.O. Box 83720, Boise, ID 83720-0036. A copy of the prior authorization request form is attached.

Cesarean–Section Four (4) Day Length of Stay

Idaho Medicaid has revised its current policy of reimbursement for C–sections. This policy overrides the information previously sent to providers in the December 2002 Medicaid Information Release MA02–40.

Effective for dates of service on or after **September 1, 2003**, when billing for a C–section, please use the appropriate diagnosis code indicating the reason for the C–section. The following range of diagnoses will have a four (4) day length of stay and will require a review with the Department's Quality Improvement Organization, Qualis Health, if the patient is not discharged after the fourth day. Diagnosis codes 669.70 and 669.71 will no longer be reimbursed.

Contact Qualis Health toll–free at 800-783-9207 for a telephonic review or fax your request to 800-826-3836.

Diagnosis Code (additional 5th digit required)	**Description**
642.5 *(0,1,2,4)*	Severe pre–eclampsia
652.2-652.8 *(0,1,3)*	Malposition and malpresentation of fetus
653.4 *(0,1,3)*	Fetopelvic disproportion
654.2 *(0,1,3)*	Abnormality of organs and soft tissues of pelvis, previous cesarean delivery
659.7 *(0,1,3)*	Abnormality in fetal heart rate or rhythm
660.0-660.8 *(0,1,3)*	Obstructed labor
661.00-661.43	Abnormality of forces of labor
663.1 *(0,1,3)*	Umbilical cord around neck, with compression
663.4 *(0,1,3)*	Umbilical cord complications, short cord
763.4	Fetus or newborn affected by other complication of labor and delivery, cesarean delivery
V30.01	Single liveborn, born in a hospital, delivered by cesarean delivery
V31.01	Twin, mate liveborn, born in a hospital, delivered by cesarean delivery
V32.01	Twin, mate stillborn, born in a hospital, delivered by cesarean delivery
V33.01	Twin, unspecified, born in a hospital, delivered by cesarean delivery
V34.01	Other multiple, mates all liveborn, born in a hospital, delivered by cesarean delivery
V35.01	Other multiple, mates all stillborn, born in a hospital, delivered by cesarean delivery
V36.01	Other multiple, mates live– and stillborn, born in a hospital, delivered by cesarean delivery
V37.01	Other multiple, unspecified, born in a hospital, delivered by cesarean delivery

If you have questions regarding the information contained in this release, please contact Colleen Osborn (208) 364-1923. Thank you for your continued participation in the Idaho Medicaid Program.

Attachment 1

Positron Emission Tomography (PET) HCPCS Codes

HCPCS Code	Description of Service
G0030	PET myocardial perfusion imaging (following previous PET G0030–G0047); single study, rest or stress (exercise and/or pharmacologic)
G0031	PET myocardial perfusion imaging (following previous PET G0030–G0047); multiple studies, rest or stress (exercise and/or pharmacologic)
G0032	PET myocardial perfusion imaging (following rest SPECT, 78464); single study, rest or stress (exercise and/or pharmacologic)
G0033	PET myocardial perfusion imaging (following rest SPECT, 78464); multiple studies, rest or stress (exercise and/or pharmacologic)
G0034	PET myocardial perfusion imaging (following stress SPECT, 78465); single study, rest or stress (exercise and/or pharmacologic)
G0035	PET myocardial perfusion imaging (following stress SPECT, 78465); multiple studies, rest or stress (exercise and/or pharmacologic)
G0036	PET myocardial perfusion imaging (following coronary angiography, 93510-93529); single study, rest or stress (exercise and/or pharmacologic)
G0037	PET myocardial perfusion imaging (following coronary angiography, 93510-93529); multiple studies, rest or stress (exercise and/or pharmacologic)
G0038	PET myocardial perfusion imaging (following stress planar myocardial perfusion, 78460); single study, rest or stress (exercise and/or pharmacologic)
G0039	PET myocardial perfusion imaging (following stress planar myocardial perfusion, 78460); multiple studies, rest or stress (exercise and/or pharmacologic)
G0040	PET myocardial perfusion imaging(following stress echocardiogram 93350); single study, rest or stress (exercise and/or pharmacologic)
G0041	PET myocardial perfusion imaging(following stress echocardiogram 93350); multiple studies, rest or stress (exercise and/or pharmacologic)
G0042	PET myocardial perfusion imaging (following stress nuclear ventriculogram 78481 or 78483); single study, rest or stress (exercise and/or pharmacologic)
G0043	PET myocardial perfusion imaging (following stress nuclear ventriculogram 78481 or 78483); multiple studies, rest or stress (exercise and/or pharmacologic)
G0044	PET myocardial perfusion imaging (following rest ECG, 93000); single study, rest or stress (exercise and/or pharmacologic)
G0045	PET myocardial perfusion imaging (following rest ECG, 93000); multiple studies, rest or stress (exercise and/or pharmacologic)
G0046	PET myocardial perfusion imaging (following stress ECG, 93015); single study, rest or stress (exercise and/or pharmacologic)
G0047	PET myocardial perfusion imaging (following stress ECG, 93015); multiple studies, rest or stress (exercise and/or pharmacologic)
G0125	PET imaging regional or whole body, single pulmonary nodule
G0210	PET imaging whole body; diagnosis; lung cancer, non–small cell
G0211	PET imaging whole body; initial staging; lung cancer, non–small cell
G0212	PET imaging whole body; restaging; lung cancer, non–small cell
G0213	PET imaging whole body; diagnosis; colorectal cancer

G0214	PET imaging whole body; initial staging; colorectal cancer
G0215	PET imaging whole body; restaging; colorectal cancer
G0216	PET imaging whole body; diagnosis melanoma
G0217	PET imaging whole body; initial staging; melanoma
G0218	PET imaging whole body; restaging; melanoma
G0219	PET imaging whole body; melanoma for non–covered indications
HCPCS Code	**Description of Service (continued)**
G0220	PET imaging whole body; diagnosis; lymphoma
G0221	PET imaging whole body; initial staging; lymphoma
G0222	PET imaging whole body; restaging; lymphoma
G0223	PET imaging whole body or regional; diagnosis; head and neck cancer; excluding thyroid and CNS cancers
G0224	PET imaging whole body or regional; initial staging; head and neck cancer; excluding thyroid and CNS cancers
G0225	PET imaging whole body or regional; restaging; head and neck cancer; excluding thyroid and CNS cancers
G0226	PET imaging whole body; diagnosis; esophageal cancer
G0227	PET imaging whole body; initial staging; esophageal cancer
G0228	PET imaging whole body; restaging; esophageal cancer
G0229	PET imaging; metabolic brain imaging for pre–surgical evaluation of refractory seizures
G0230	PET imaging; metabolic assessment for myocardial viability following inconclusive SPECT study
G0252	PET imaging for initial diagnosis of breast cancer and/or surgical planning for breast cancer
G0253	PET imaging for breast cancer, staging/restaging of local regional recurrence, or distant metastases
G0254	PET imaging for breast cancer, evaluation of response to treatment, performed during course of treatment

Attachment 2

PET SCAN PRIOR AUTHORIZATION INTAKE FORM

FAX TO: Idaho Medicaid Care Management

Fax: (208) 364-1864 Phone: (208) 364-1824

Today's Date	
Name of Requesting Agency	
Address	
Phone #	
Fax #	
Contact Person	
Agency Medicaid Provider #	
Ordering Physician	
Healthy Connections Physician and referral number (if applicable)	
Patient Name	
Medicaid #	
Diagnosis	
ICD–9 Codes	
Reason for PET Scan Request	
Type of PET Scan Requested	
HCPCS Billing Code (i.e. G–code)	
Requested Date–of–Service	
Supporting Documents ***Required*** – please attach the following	Summary of patient's medical condition □ Current History and Physical □ Previous CT Scan results (if applicable) □ Previous MRI results (if applicable) □
Medicaid Use Only	
Prior Authorization #	
Dates Approved	
Request Denied	
Reason Denied	
Log Completed by Staff Signature	

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MEDICAID INFORMATION RELEASE
May 2003

TO: HOSPITAL PROVIDERS
in Alaska, Idaho and Washington

FROM: QUALIS HEALTH

SUBJECT: WHAT ARE THE CHANGES IN THE 2003 VERSION OF THE INTERQUAL® CRITERIA?

Qualis Health issued a bulletin in April 2003 to all facilities in the states of Alaska, Idaho and Washington to inform them that we were implementing the 2003 version of the InterQual® Criteria sets on Monday, April 28, 2003. At that time, we stated we would send a subsequent provider bulletin in May 2003 detailing the major changes to this latest version of the InterQual® Criteria sets.

The following information is a summary of those InterQual® criteria changes relevant to Qualis Health review in the 2003 version.

In addition, Qualis Health is including information on how we will be applying the 2003 updated InterQual® Discharge Screens.

Finally, we are providing you with a utilization review tool titled, *Inpatient Review Concept Template*, to help you identify the necessary clinical information we need to document as a result of these changes with the InterQual® Criteria sets.

Introducing a "Care Facilitation" Approach: The Next Step in the Case Management Paradigm

The 2003 InterQual® version presents a new acute level of care content in the Adult Acute Criteria that can assist nurse reviewers in managing the timely identification of discharge planning opportunities and appropriate alternate levels of care. InterQual® will be extending care facilitation features to other inpatient level of care criteria over the next several annual releases.

This change in the application of InterQual® criteria results in a major shift from Qualis Health utilizing physician advisors strictly to determine if a case should be non–certified to using physician advisors as consultants in a patient's discharge plan.

Due to this change, listed below are three key Qualis Health decisions on the application of 2003 Updated InterQual® Discharge Screens:

When a review is not meeting the Intensity of Service (*IS), Qualis Health nurse reviewers will refer the review to a Qualis Health Medical Director. This is a change. Previously if a review did not meet IS, the nurse reviewer went to the discharge screens and if it did not meet the discharge screens the nurse reviewer could grant a grace day.

For the new care facilitation IS requirements that require a review to meet one IS criteria and discharge review, Qualis Health nurse reviewers will refer the review to a Qualis Health Medical Director. The **discharge review** is new with the 2003 InterQual® criteria.

When using the ≥ Three (3) *IS indicators Qualis Health nurse reviewers will continue to give up to 3 grace days for this. The 2003 InterQual® Criteria change is to ≥ Three (3) *IS indicators and Discharge Review.

Cases taken to Medical Director Review for any reason rely upon the physician's professional judgment, not on InterQual®. InterQual® criteria are only used for non–physician review.

Major InterQual® Criteria Updates and Changes per McKesson

Acute Criteria

With the development of an expanded Behavioral Health Criteria suite in 2003, InterQual® is removing Chemical Dependency and Mental Health criteria from the Acute Criteria set. InterQual® will continue to include criteria for medically related conditions that require observation, acute care or critical care (e.g., detox/DTs, withdrawal syndromes, seizures, eating disorders with abnormal lab values and weight loss) in the Acute Criteria.

Procedures Criteria

Based on client feedback and market research, we have streamlined the book format of the Procedures Criteria for adults: InterQual® has provided the 100 most widely used adult procedures in two volumes, plus a CD–ROM that contains the full complement of procedures criteria. The ability to select and print procedures from the CD ensures you can include any procedure relevant to your organization in your binder. Pediatric Procedures will continue to be published as a separate book.

InterQual® has introduced prompts for "controversial" procedures (e.g., Virtual Colonoscopy) to encourage a primary reviewer to gather and document patient–specific clinical information that will speed the secondary medical review process.

New criteria have been added: Lung Volume Reduction Surgery (Cardiothoracic), Supracervical Hysterectomy (OB/GYN), and Weight Loss Surgery (General).

In light of recent clinical research, notes to Hormone Replacement Therapy have been updated.

Behavioral Health Criteria

The 2003 criteria release will include a Residential psychiatric criteria set for adolescents—a first in the industry—as well as Chemical Dependency and Dual Diagnosis criteria for this age group. Managed care clients licensing the Behavioral Health Level of Care Continuum will receive this as part of their current license.

This release introduces a behavioral health procedure supplement—Acute Electroconvulsive Therapy (ECT)—to the Adult, Adolescent and Geriatric Psychiatry products.

Rehabilitation Criteria

InterQual® has added Pediatric Rehabilitation to the Rehabilitation Criteria product.

Durable Medical Equipment Criteria

New DME subsets include Below Knee Prosthetics in a new category, Prosthetics; Continuous Passive Motion, Knee, and Seat Lift Mechanisms (Standard Equipment); and Secretion Clearance Devices (Pulmonary Devices).

For other changes please go to the website, www.InterQual.com.

These include changes to Imaging Criteria and the Outpatient Rehabilitation & Chiropractic Criteria.

Qualis Health Utilization Review Tool

Qualis Health has developed an Inpatient Review Concept Template and a Daily Inpatient Review Worksheet that utilization review staff can use as a guide to gather relevant information needed for initial and concurrent reviews. Please consider using these when providing information for review– either by fax, telephone, voicemail, or in person. Our nurse reviewer staff will also be using this template during telephonic UR contact. If we do not obtain the information necessary to conduct the requested review(s), Qualis Health will contact the utilization review department to obtain additional information.
(See Attachment 1, *Inpatient Review Concept Template* and Attachment 2, *Daily Inpatient Review Worksheet*)

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Attachment 1

This is provided as a tool to help organize information that will help patients get medically necessary services at the right level of care and at the right time while meeting Qualis Health's need for appropriate InterQual® documentation. Please consider the following as a 'guide', not a requirement or guarantee of payment for admission or for continued stay review.

Demographics:
Patient name, ID number
Attending name, pager number and best time for a Qualis Health Medical Director to call if needed
The day or dates under review
SI [Symptom Intensity]– How sick is the patient? This places the patient's services in context with their clinical condition and is needed both for initial review and for concurrent review
What is the main clinical issue?
Abnormal vital signs?
Pain present– where, what is cause?
Neurological Status: alert to obtunded
Brief description of diagnostic tests [especially if lab or x–rays are abnormal]
Any consultations and evaluations or procedures?
IS [Intensity of Services]– What care is the patient receiving?
IV medications and frequency
Any IV PRN meds given for nausea, pain? How often each day?
IV fluids/ TPN
Blood or blood products [should have a HCT as a reason]
Oxygen needed? FiO2 and route? ABGs done or O2 sats?
Diet/ Tube feeds/ gavage [what is infant's weight?]
If patient is on a sliding scale, what were high/low glucose values? How many coverage units were given on each day [not the routine doses]?
Wound management: describe wound and dressing/ debridement/ special issues
Any other treatments or therapies?
DS [Discharge Screens]– What is the long–term plan?
What is the expected destination after the hospitalization?
What discharge planning activities are being done?
What care needs are there post–discharge? Educational needs?
Are there significant psycho–social issues?

	Contact Number	Fax Number
Alaska Medicaid Pre–Admission	800-783-9207	800-826-3630
Idaho Medicaid Pre–Admission	800-783-9207	800-826-3836
L & I Pre–Admission	800-541-2894	877-665-0383 206-366-3378
WA Teamsters Pre–Admission	877-372-7861	206-368-2765
Private Insurance Pre–Admission	800-783-8606	206-368-2765
L&I Physician Hotline	877-665-0382	
Medicaid / Private Physician Hotline	877-292-2615	

Attachment 2

Qualis Health
Daily Inpatient Review Worksheet

DATE:

Patent Name: _____ **ID #** _____
Attending name /contact info*/best time: _____
Admit Diagnosis/Code _____ **Procedure Code** _____

[SYMPTOM INTENSITY: CLINICAL ISSUES] [INTENSITY OF SERVICES: TREATMENT] [DC SCREENS]

SI

Review covers dates from _____ ***to*** _____

What is the main reason the patient is in the hospital for this day/days?

_____
_____
_____
_____
_____
_____

Please include a brief description of progress, diagnostic tests & results, consultations, evaluations:

_____
_____
_____
_____
_____
_____

IS

IV medications & frequency:– & iv PRN meds [esp. pain] & # of times given per 24h

_____
_____
_____
_____
_____

***iv* fluids/TPN/ lipids/ rates/bolus/ blood:** _____

_____

Respiratory status/treatment _____
Nutritional status/treatment _____
Insulin coverage/ values: _____
Wound mgmt issues/frequency: _____

_____

Other treatments: _____

_____

DS

Brief description of Discharge Planning : expected destination/ care needs/ educational needs

_____
_____
_____
_____
_____

* In case the attending needs to be called by a Qualis Health Medical Director. Please identify a pager # or office number, and best time to call.

MEDICAID INFORMATION RELEASE
April 2003

TO: HOSPITAL PROVIDERS
in Alaska, Idaho and Washington

FROM: QUALIS HEALTH

SUBJECT: INTERQUAL® CRITERIA 2003 VERSION TO BE IMPLEMENTED BY QUALIS HEALTH

Qualis Health will begin using the 2003 version of the InterQual® Criteria sets developed by McKesson Health Solutions LLC on **Monday, April 28, 2003**. Initially, Qualis Health began using the criteria in September 2002, and will now implement the latest version of InterQual® for non–Medicare reviews conducted on and after **April 28, 2003**. This criteria helps the organization assess the necessity and appropriateness of health services delivered to the various populations served by Qualis Health throughout the West, including Medicaid agencies, other government agencies, and members of private and self–funded health plans.

The InterQual® Criteria sets licensed by Qualis Health include tools to facilitate care decisions for acute, sub–acute, skilled nursing facility, and long–term acute care; rehabilitation; home care; and behavioral health care as well as care planning decisions for medical and surgical procedures and durable medical equipment. Qualis Health plans to use the criteria in providing all of its utilization and case management services.

Providers may obtain the InterQual® criteria on a lease basis from McKesson by contacting Dean Bushey at 1-800-522-6780, extension 3217. Additional information is also available on the web at www.interqual.com. Providers are not required to lease the new criteria set, and may request specific criteria on a case–by–case basis, at no cost, from Qualis Health.

NOTE: We anticipate faxing a subsequent bulletin to all facilities in the states of Alaska, Idaho and Washington by the end of May 2003 detailing the major changes to this latest version of the InterQual® Criteria sets.

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATION RELEASE 2003–29
April 11, 2003

TO: ALL GENERAL ACUTE HOSPITALS, CHILDREN'S HOSPITALS AND INDIAN HEALTH SERVICE HOSPITAL

FROM: Paul Swatsenbarg, Deputy Administrator, Division of Medicaid

SUBJECT: NON–CITIZEN EMERGENCY MEDICAL DOCUMENTATION FOR LABOR AND DELIVERY AND OTHER EMERGENCY MEDICAL REQUESTS

Beginning April 1, 2003, the process for approving labor and delivery for Non–Citizen Emergency Medical services has changed.

Labor and Delivery Services

Requests for payment of C–Sections and vaginal deliveries for non–citizens require review by the Department. Consideration for coverage for non–citizens requires submission of the following documentation:

- Admission record (including date and time of admission)
- Discharge summary (including date and time of discharge)
- Doctor's delivery notes

Other Medical Services

All other requests for emergency medical services for non–citizens also require review. The dates of service should be included with the following documentation:

- History and physical
- Admission and discharge summaries
- Doctor's orders and doctor's progress notes
- Emergency room report

Providers should submit the request for consideration of payment with all the required documentation to the local Self–Reliance Services (SRS) office. Requests will be reviewed by the local SRS and the Medicaid Care Management Bureau. The local SRS office will notify each non–citizen applicant of the determination.

If the request for review is initiated by the hospital, the SRS will notify the hospital provider of the determination.

If you have questions regarding the information in this notice, please contact Carolyn at (208) 364-1827. Thank you for your continued participation in the Idaho Medicaid Program.

PS/cbp

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATION RELEASE #MA02–29
October 2002

TO: ALL PHYSICIANS

FROM: PAUL SWATSENBARG, Deputy Administrator, Division of Medicaid

SUBJECT: REIMBURSEMENT FOR ABORTIONS

A recent court ruling that has interpreted an amendment to statute has changed the requirements for state–funded abortions. For abortions performed with **dates of service on or after July 1, 2002**, the following rules apply:

The state will no longer reimburse for abortions performed solely to save the health of the woman.

Medicaid will pay for an abortion only under the following circumstances:

When a physician certifies in writing that, on the basis of his/her professional judgment, an abortion is necessary to save the **life** of the woman. The physician's certification must contain the name and address of the woman.

When the pregnancy is the result of rape or incest, and

If rape or incest is determined by a court of law, a copy of the court determination of rape or incest is submitted with the request for payment; or

If no court determination has been made,

Documentation is provided that the rape or incest was reported to a law enforcement agency, or

Certification in writing by a licensed physician is provided that, in the physician's professional opinion, the woman was unable, for reasons related to her health, to report the rape or incest to a law enforcement agency. The certification must include the name and address of the woman; or

Documentation is provided that the woman was under the age of eighteen (18) at the time of sexual intercourse.

These documentation requirements can also be found in IDAPA 16.03.09.095. If you have any questions, please contact Elvi Antonsson at (208) 334-5795, ext. 17.

Your participation in the Medicaid program is appreciated.

PS/ea

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IDAHO DEPARTMENT OF HEALTH & WELFARE

MEDICAID INFORMATION RELEASE # 2002–02
January 17, 2002

TO: **HOSPITAL PROVIDERS**

FROM: **RANDY W. MAY, Deputy Administrator, Division of Medicaid**

SUBJECT: **INPATIENT RE–CERTIFICATION REVIEWS CHANGED TO THREE–DAY LOS**

Effective for inpatient admissions that begin on or after February 3, 2002, a new length of stay (LOS) criteria will be used to determine when the admission requires a [Qualis Health]
re–certification review. All inpatient stays which do not require a pre–admission review (see the Select Pre–Authorization List in the [Qualis Health] Provider Manual), must be reviewed if the stay exceeds three days.

If after a three day stay, the patient is not discharged by the next day (count day one of the admission as day one), a review must be obtained on or before day four, and thereafter at intervals determined by [Qualis Health]. If the re–certification date falls on a weekend or holiday, follow the procedure detailed in the [Qualis Health] Provider Manual available from [Qualis Health] and on the Internet at www.qualishealth.org/idahomedicaid.htm. If timely review is not conducted, penalties may apply.

[Qualis Health] may be reached at 1- 800-783-9207 Monday through Friday 7:30 A.M. to 6:45 P.M. Mountain Time or 6:30 A.M. to 5:45 P.M. Pacific Time. FAX 1-800 826-3836.

Questions regarding this information may be directed to Arlee Coppinger, Contract Officer, at (208) 334-5754.

Thank you for your continued participation in the Idaho Medicaid program.

RWM/ARC/bdr

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This Provider Manual was produced for Idaho State Department of Health and Welfare,
Division of Medicaid, Idaho Medicaid Operations
by
Qualis Health
Seattle, Washington

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